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# Pennsylvania Medicine

Vol. 83, No. 1 JANUARY 1980

## THE VOICE OF MEDICINE

Proceedings of the 1979 House of Delegates Meeting

2443
TS INDEX MEDICUS
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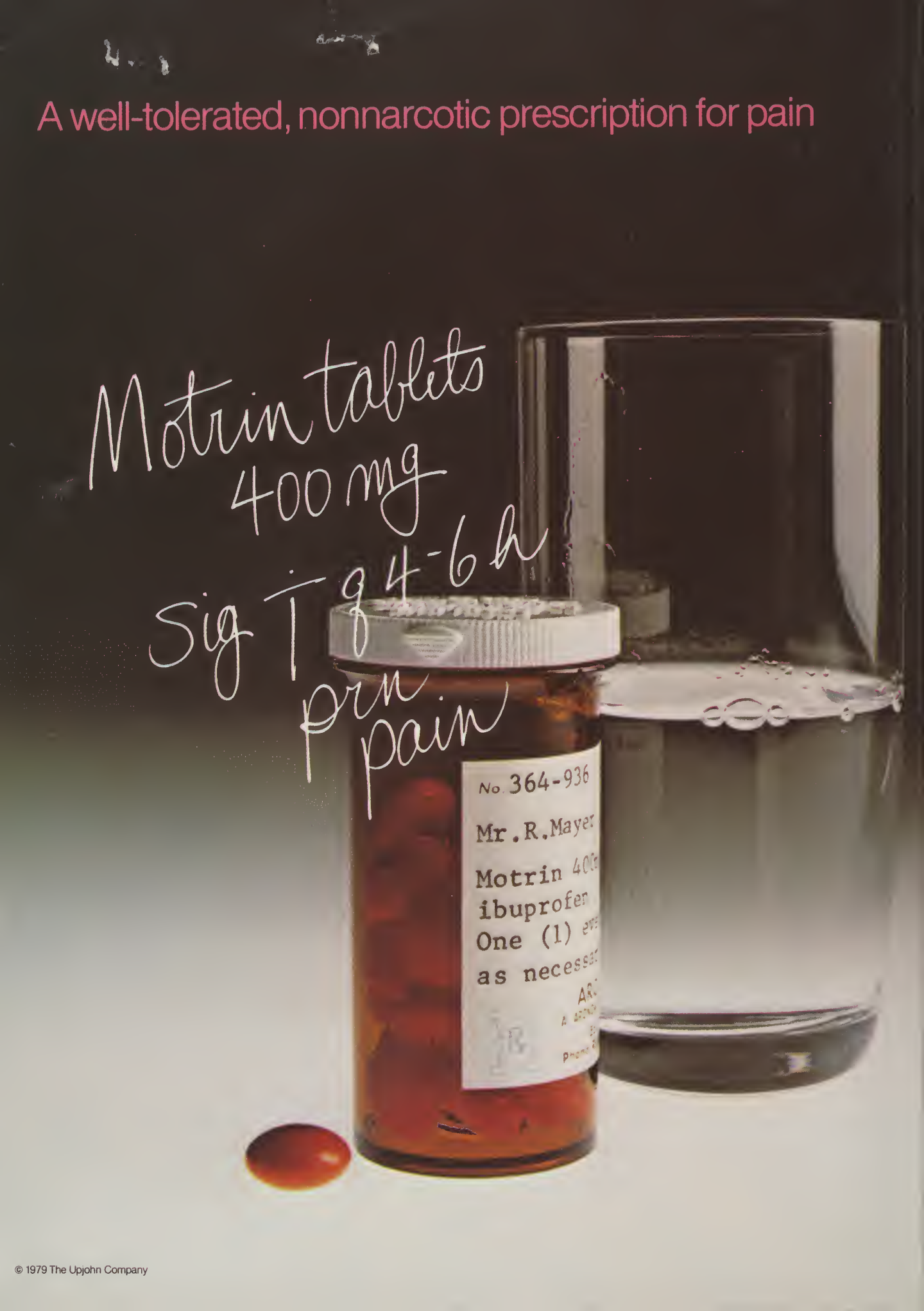
# A well-tolerated, nonnarcotic prescription for pain

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# Motrin® now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

| Time after drug administration (hour) | | .5 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| Mean relief-of-pain scores* (No. patients reporting) | Motrin 400 mg ibuprofen | .89 (108) | 1.25 (108) | 1.36 (108) | 1.28 (107) | 1.19 (106) |
| | Darvon 65 mg propoxyphene | .66 (100) | .99 (99) | 1.13 (96) | .99 (96) | .80 (96) |
| Statistical significance | | $p<0.02$ | $p<0.01$ | $p<0.05$ | $p<0.02$ | $p<0.002$ |

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

# Motrin 400 mg TABLETS
## ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

# Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

**Motrin® Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

***Incidence greater than 1%***

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

***Incidence less than 1 in 100***

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

***Causal relationship unknown***

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

**Caution:** Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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**June 6-7, 1980**

**Faculty**

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Peter G. Watson, M.D. George L. Spaeth, M.D.

Members of the Glaucoma Service Staff of the Wills Eye Hospital

Dr. Robert N. Shaffer will present the Edmund B. Spaeth Lecture

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**For further information please contact:**
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**c/o Glaucoma Service**
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# medigram

**PMS HEADQUARTERS EXPANDS; $2.9 MILLION CONTRACT LET**

The PMS Building Committee on December 19 awarded the contract for the expansion of the headquarters building to Miller and Norford, Inc., Lemoyne. The contracting firm submitted the lowest of eight bids received. Groundbreaking is scheduled for this month. The project is expected to be completed in the spring of 1981.

**CO-OP CLOSES DOORS DECEMBER 31, 1979**

The Pennsylvania Medical Cooperative went out of business as 1979 ended. An independent study, commissioned October 31 by the PMS Board of Trustees, found that an inadequate market created a no growth situation for the Co-op. At a special meeting December 19, the PMS Board recommended liquidation. Later the same day, the Co-op Board of Directors planned the phase-out. Co-op members received details of the termination of business by letter.

**PHYSICIAN ASSISTANTS MUST BE REGISTERED**

The State Board of Education and Licensure in December notified some 600 physician assistants working in Pennsylvania of the January 1, 1980 deadline for registration with the board. Act 79 requires that the assistants and their supervising physicians register or be subject to disciplinary action, Philip E. Ingaglio, MD, board chairman, said in his letter.

**MEDICAL PROTECTIVE RATES UP 13.5 PERCENT FEBRUARY 1**

A 13.5 percent across the board increase in premiums was the Insurance Department's answer to Medical Protective's rate filing for a 31.9 percent increase in malpractice insurance premiums. The increase becomes effective February 1, 1980. Some 6,300 insureds will pay the higher premiums.

**CAT FUND SURCHARGE 10 PERCENT IN 1980**

The Catastrophe Loss (CAT) Fund, established under the Pennsylvania's medical malpractice law, will impose a 10 percent surcharge in 1980 on health providers as defined in the law. The CAT Fund pays malpractice awards, up to $1 million, exceeding $100,000 per occurrence and $300,000 annual aggregate, the basic limits of coverage required by Act 111. This is the first CAT Fund surcharge in two years. The Society's ad hoc committee to consider amendments to Act 111 has expressed concern about the methodology employed by the CAT Fund in imposing surcharges, and seeks a more scientific approach to keeping the fund viable. The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) has announced that its insureds can expect to receive an invoice reflecting the full annual CAT Fund surcharge as part of PMSLIC's second quarter billing.

**COMMISSIONER APPROVES PMSLIC PREMIUM CUT**

Insurance Commissioner Harvey Bartle, III has approved a 6.2 percent decrease in malpractice insurance rates for the Pennsylvania Medical Society Liability Insurance Company.

PMS CREDIT UNION PAYS 6 PERCENT DIVIDEND

Only in its first full year of operation, the PMS Credit Union paid a 6 percent dividend to shareholders December 31, 1979. William A. Shaver, MD, of Lebanon, PMSCU president, said the Board of Directors declared the dividend at a meeting December 20.

MUMPS IMMUNIZATION SCHOOL REQUIREMENT

An amendment to the state school immunization law has added mumps vaccine as a requirement. Children entering kindergarten or first grade for the first time in 1980 will need immunization against mumps as well as polio, measles, rubella, diphtheria, and tetanus. The Pennsylvania Department of Health said mumps has decreased about 90 percent nationwide since the vaccine was introduced in 1968. The health department also announced a 97 percent immunization compliance rate among children starting kindergarten or first grade in 1979. Some 110,000 children received the full dosage of vaccine for the five diseases previously listed.

ABORTION SURVEY MAILED JANUARY 3

An all member survey on the PMS abortion policy was mailed January 3, 1980 in a letter from Matthew Marshall, Jr., MD, president. Members who have not yet responded are urged to do so.

STATE BOARD ELECTS NEW SECRETARY

Loretta M. Frank was elected new secretary to the State Board of Medical Education and Licensure in December. Ms. Frank replaces Dorothy Bupp, who served as secretary more than five years. Ms. Bupp will continue with the state board as education credentials evaluator. Ms. Frank joins the state board after 17 years experience with the Pennsylvania Department of Health.

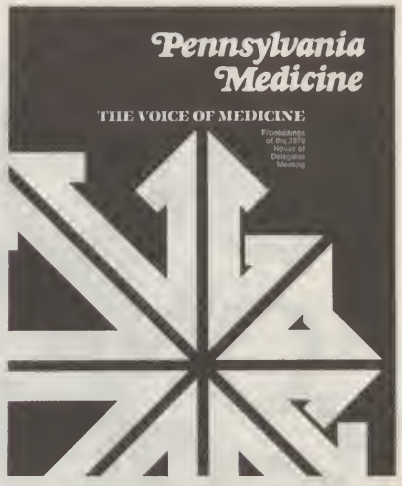
INDOCHINESE REFUGEES HAVE HEALTH PROBLEMS

As many as half of the 10,000 Indochinese refugees expected to arrive in Pennsylvania in 1980 will have serious health problems including tuberculosis, venereal diseases, malaria, and parasitic infections. Children entering Pennsylvania schools (kindergarten or first grade) will need the immunizations required by Pennsylvania law. Physicians involved in the care of the refugees have access to an Indochinese Refugee Help Line operated by Tressler Lutheran Services, Camp Hill. The toll free line operates seven days a week from 8 a.m. to 9 p.m. Interpreters speak Vietnamese, Cambodian, Laotian, Chinese, and French. The number is 800-382-1269.

HEALTH SECRETARY MULLER SWORN IN DECEMBER 10

H. Arnold Muller, MD, of Hershey, was sworn in as secretary of health December 10. He is chief of emergency medicine at the Milton S. Hershey Medical Center. On the same day he took office, Dr. Muller delivered a keynote address to an audience of 500 at the Governor's Conference on HMOs in Hershey. He urged physicians to become involved in and work with HMOs. "You (physicians) need not fear HMOs," he said, "since it is unlikely that HMOs will ever replace the fee-for-service, third party reimbursement system." Currently ten HMOs are operational in Pennsylvania and serve about 100,000 patients.

Pennsylvania Medicine

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**PENNSYLVANIA MEDICINE**
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

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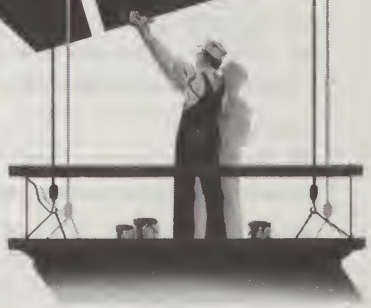
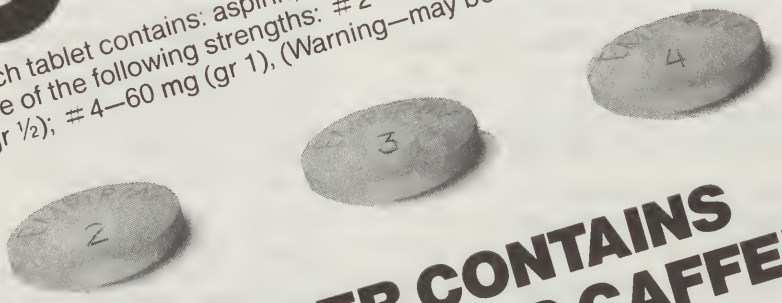


Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg (gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)

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# Reduction of panel size major PMS legislative victory

PMS scored a major victory as the first year of the 1979-80 legislative session ended when the House passed S.B. 846, reducing the size of health care malpractice arbitration panels. Little other health related legislation saw final action in 1979, although many bills of interest to medicine were introduced and Society leaders testified at hearings.

**Arbitration panel size reduced**

The Pennsylvania House of Representatives first amended and then on December 3 unanimously passed S.B. 846. The bill reduces the size of arbitration panels to hear health care malpractice cases from seven to three members—a physician, a lawyer, and a lay person. The Senate unanimously adopted the Act 111 amendment this summer. John J. Danyo, MD, of York, now PMS Fifth District trustee, testified for the Society and urged the reduction in panel size so that the arbitration system could keep up with the case load.

Attempts to amend the bill slowed its progress through the House. PMS agreed to two amendments: Imposition of a 90-day limit to form panels after plaintiffs filed certificates of readiness; and a severability clause, insuring that Act 111 will not be struck down totally should the Pennsylvania Supreme Court find any part of it unconstitutional in a currently pending test case.

The Senate concurred in the amendments, and the bill is expected to be signed by Governor Thornburgh, who endorsed reducing the size of the panels in his "State of the Commonwealth" message.

Meanwhile, the Office of Arbitration Panels for Health Care has increased fees for panel members. Health care providers and attorneys will receive $150 a day; lay persons, $100. The increase in fees should induce potential panelists, especially the professionals, to take time from their work to serve.

**Personal checks accepted**

Perturbed by the senseless requirement that physicians pay for their license renewals with certified checks or money orders, the 1978 House of Delegates demanded legislative action be taken. The Society responded by supporting House Bill 215, permitting payment by personal check of license renewals.

The House and Senate passed the bill but Governor Thornburgh vetoed it. Physicians and the Society triumphed when the General Assembly overruled the veto and the bill became Act 39 of 1979.

**Emergency services continue**

Act 44 of 1979 extends Emergency Medical Service Act of 1976 to 1982. Testifying on behalf of the bill, William E. DeMuth, MD, a member of PMS Council on Education and Science, urged reenacting the 1976 law so that the program could continue its emergency services. The bill became law upon the approval of both Chambers and the Governor.

**Certificate of need passed**

High on last year's list of issues facing the General Assembly was the question of certificate of need. House Bill 308, drafted by the Hospital Association of Pennsylvania, brings the state into compliance with the federal certificate of need requirements for hospitals.

R. William Alexander, MD, Reading radiologist, testifies on behalf of PMS concerning the drafted Health Care Facilities Licensure bill.

The House passed the bill after incurring the wrath of the Health Systems Agencies in the state.

When it went to the Senate, the bill received support from John B. Lovette, MD, PMS president. Dr. Lovette commended the bill before the Senate's Public Health and Welfare Committee, but recommended that the health care policy board be deleted from the bill.

As passed by the Senate, H.B. 308 authorizes the secretary of health to establish a certificate of need program. The policy board will assist the secretary but only in an advisory capacity.

When the Governor signed the bill, it became Act 48 of 1979.

**Cancer research encouraged**

Two House bills, H.B. 230 and H.B. 231, were introduced to create a state cancer control and research advisory board and fund.

H.B. 231 required that monies from an increased tax rate on cigarettes be designated for the cancer research fund. The House finance Committee rejected H.B. 231.

The House passed H.B. 230 which established the Pennsylvania Cancer Control and Research Advisory Board.

**Nonclinician as commissioner**

The Senate and House passed S.B. 502, a bill eliminating from the Mental Health Act the requirement that the Commissioner of Mental Health have seven years clinical experience. The bill retains the requirement that the commissioner be a psychiatrist.

The Society worked hard to defeat amendments allowing psychologists to serve at the post. The bill awaits the Governor's action.

**Loan fund for students**

Senate Bill 800, which establishes special loan funds for medical students in the Pennsylvania Higher Education Assistance Agency, is in committee. The Society supports this and other legislation on behalf of medical students receiving financial aid.

# Smallpox vaccine obsolete, health department says

Except for a laboratory accident in England in 1978, no cases of smallpox have occurred anywhere since the last naturally acquired case was reported in Somalia in October 1977.

As of October 1979 the countries in the Eastern Horn of Africa, including Somalia, have become eligible for certification as smallpox-free; these should be the last countries in the world to receive WHO certification as smallpox-free.

In the U.S., routine smallpox vaccination was discontinued for children in 1971, and for hospital employes in 1976. As of 1978, smallpox vaccination has not been required for travelers entering the U.S.

In a recent issue of the Morbidity and Mortality Weekly Report (MMWR), four separate, serious, and avoidable adverse reactions to smallpox vaccine were reported.[1]

Currently, no medical or epidemiologic reasons justify countries requiring smallpox vaccine for anyone except the few laboratory workers likely to have contact with the variola virus.[2]

The number of countries which, for administrative reasons, still require vaccination as a condition of entry is declining steadily. Most of these countries are in Africa and Asia. In the Americas now, only Belize and Bolivia require vaccination as a condition of entry.

The vast majority of U.S. travelers go to Canada, Mexico, Europe, Japan, and Israel. These areas do not require smallpox vaccination for entry.

When counseling prospective travelers, health care providers should be aware that the World Health Organization's International Health Regulations provide for smallpox vaccination waiver letters. If the travelers are visiting a country that requires smallpox vaccination, waivers may be issued to those for whom vaccination is contraindicated for health reasons.

The apparent success of the smallpox eradication effort and the risks associated with smallpox vaccination prompted several health agencies to recommend that physicians and clinics provide travelers to countries requiring smallpox vaccination with a waiver letter. This letter should be written on the physician's stationery, signed by the physician, dated, and validated with the "uniform stamp" for international travel.

The Center for Disease Control reports that countries requiring vaccination for entry have accepted such letters. Yet, how long such countries will continue to accept waiver letters from healthy travelers is questionable. Prospective travelers should check with the appropriate visa-issuing agency as to whether such policy is effective in the areas where they plan to visit.

*This article was prepared by the epidemiology division of the Pennsylvania health department.*


REFERENCES

1. *MMWR 28:*265, 1979.
2. World Health Organization: Functioning of the International Health Regulations (1969) for the period 1 January to 31 December 1977. *Weekly Epidemiological Record 53:*354-355, 1978.


## Department of Health furloughs personnel

Furloughs for 118 employes and the abolition of 78 vacant positions were announced by the state's health department on November 9, 1979. These actions were taken to meet the General Assembly's reductions to the Governor's proposed 1979-80 budget.

The cuts trimmed the department's workforce by 11.4 percent.

Acting health secretary Donald Reid, MD, said the furlough notices, mailed to employes on November 9, were effective December 10.

## Surgery fact book available from ACS

The 1979 edition of the *Socio-Economic Factbook for Surgery* now is available from the American College of Surgeons. The booklet provides descriptive and statistical information on surgical manpower, use of medical services, and medical economics. Some factual highlights of the book include:

- The total number of medical students in the U.S. increased 141 percent between 1949-50 and 1977-78.
- In 1977, per 100,000 population in the U.S., there were 194 physicians, 47 surgeons, and 65 primary care physicians.
- The total number of operations increased 34 percent from 15.8 million in 1971 to 21.2 million in 1977. The rate of tonsillectomy and adenoidectomy per 1,000 population decreased from 4.8 in 1971, to 2.9 in 1977.
- In 1971, appendectomy ranked ninth among the ten most frequently performed operations and cesarean section did not rank. Appendectomy was not among the top ten in this category in 1977, but that year, cesarean section ranked eighth.
- National health expenditures increased 178 percent from $69.2 billion in 1970 to $192.4 billion in 1978.
- Blue Cross/Blue Shield subscribers numbered 38.8 million in 1950, and 86 million in 1977, a 122 percent increase.
- Blue Cross/Blue Shield and other hospital medical plan benefit payments rose from $590 million in 1950 to $21 billion in 1977, an increase of 3,459 percent.

The *Socio-Economic Factbook for Surgery, 1979* is available free of charge from the Department of Surgical Practice, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

## Ultrasound society announces officers

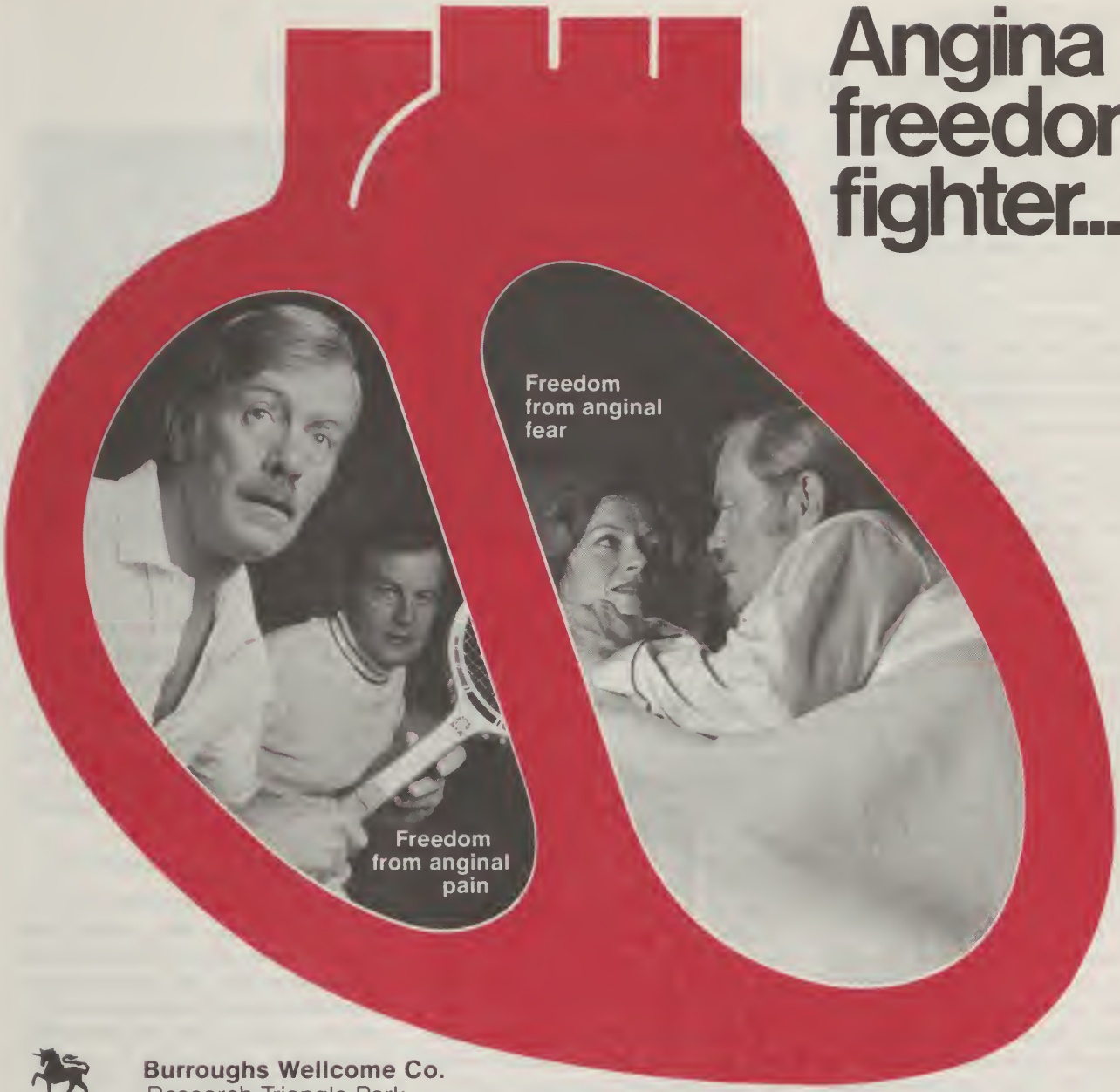
At a recent meeting the Greater Delaware Valley Ultrasound Society elected the following officers for the 1979-1980 year: Harvey L. Nisenbaum, MD, president; William Ritchie, MD, vice president; and Lester H. Wurtele, MD, treasurer.

The society meets the third Tuesday of each month, September through May from 6:00 to 8:00 p.m. at the Thompson Auditorium, Thomas Jefferson University Hospital, Philadelphia.

Meetings include guest speakers and case presentations and are approved for Category 1 credit.

For further information contact Harvey L. Nisenbaum, MD, Dept. of Radiology, Albert Einstein Medical Center, York and Tabor Rds., Philadelphia, PA 19141.

# Angina freedom fighter...

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PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrates, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

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# Cardilate®
## (erythrityl tetranitrate)

# Review, expectancy mark presidential reports

"An aggressive consumer advocate," Matthew Marshall, MD, demanded "is what PMS must become." Dr. Marshall repeated this charge throughout his address as president-elect at the 1979 House of Delegates session.

Dr. Marshall believes, "PMS has every opportunity to be the number one health care consumer advocate by placing Pennsylvania patients' interest first so unequivocally that the public fully realizes it."

DR. LOVETTE

DR. MARSHALL

**Health care consumer year**

As a start, he recommended that 1980 be the year of the health care consumer. He reminded the delegates that before this new name, physicians knew health care consumers as patients.

Dr. Marshall alerted his listeners to their professed standards saying, "Our ethical code requires us to be our patients' advocates through the care we give them." To serve patients better, he suggested that the Society lend an attentive ear to representatives of labor and organized minority groups.

**Areas of action**

Dr. Marshall named three areas in which delegates should take action: "To lessen the burden of physician paperwork; to improve medical staff hospital relations; and to increase the strength of organized medicine."

He challenged the Society to discover if the programs which created much of the paperwork are functioning effectively. He added that the Society needs to know if programs could be eliminated and burdens on the practicing physician lessened.

Dr. Marshall recommended that "this House request the Board of Trustees have its new planning committee adopt, as a top priority, an investigation of the growing burden of paperwork created by various programs, both those supported by PMS and those created by outside sources, and to make recommendations to the 1980 House of Delegates."

Dr. Marshall urged physicians to serve on the board of trustees and the board committees of the hospitals where they are on the medical staffs. Knowing that physicians may not be equipped to handle administrative, financial, and planning problems, Dr. Marshall recommended, that the Society's "program of assisting medical staffs be expanded to train us in this area, and that this instruction include the skills and arts of negotiation."

Dr. Marshall focused on unified membership in the remainder of his address. He made three recommendations: To commend the AMA for challenging the Federal Trade Commission's arbitrary rulings; to recruit AMA members and "to bite the bullet and reconsider unified membership;" and to capitalize on the American Osteopathic Association's change of policy to increase the number of osteopathic physician members of PMS.

**Work, work, work**

Dr. Marshall coached the team of delegates with these final words: "Let's work . . . on every hospital board and committee. Let's work . . . to give patients care, not paper. Let's work . . . to keep the FTC from eliminating the cheapest, most efficient health care delivery system, the private physician's office. Finally, I urge you to strengthen the ability of organized medicine at both the state and national level to deal with today's problems."

**Dr. Lovette reports**

Preceding Dr. Marshall's address, John B. Lovette, MD, greeted the House of Delegates in one of his last presidential acts. Dr. Lovette prepared the way for the new president by addressing most of his remarks to the past year.

**Governmental accomplishments**

Improving relations with state government proved easier in 1979 with the change from the Shapp Administration to the Thornburgh Administration. Mrs. O'Bannon, Secretary of

## College of surgeons meets in March

The American College of Surgeons will hold its Eighth Annual Spring Meeting in Toronto, Canada, March 23-27, 1980, at the Sheraton Centre Hotel.

Eight postgraduate courses for physicians will be offered. Panel discussions and a lecture on portal hypertension also will be featured.

Registration is free for fellows of the College whose dues are paid for 1979, and for participants in the Candidate group. The fee for non-fellows is $80; physicians in the full-time federal service, and surgical residents pay $40.

Advanced registration forms are available from Mr. Frank Arado, American College of Surgeons, 55 E. Erie St., Chicago, IL, 60611 (deadline February 29, 1980).

Public Welfare, met often with Society representatives, Dr. Lovette reported.

Dr. Lovette won a round of applause when he related how the Society achieved its goal of having personal checks accepted legally for license renewals. The audience also responded positively when he told of the Society's distribution of sun visor cards during the gasoline shortage.

**Chiropractic politics**

In his first recommendation, Dr. Lovette challenged the delegates to recognize that "chiropractic is much more a political reality than a scientific modality . . . . The time has come to take the chiropractic battle back to the legislatures from whence it came."

**Surge of activities**

Dr. Lovette listed new Society activities which grew in the later months of 1979:

- PMS received its second grant from the AMA to participate in its Jail Health Program.
- The Board approved the expansion of the headquarters building.
- PMS conducted its first medical reporting seminar; and
- John Rineman, executive vice president, became president-elect of the American Association of Medical Society Executives.

**No fee increases in '80**

Dr. Lovette turned his remarks to the future when, in his second recommendation, he urged physicians in Pennsylvania to declare a one year moratorium on fee increases.

He concluded by reporting on AMA membership recruitment. He noted the direct mail campaigns launched by the Council on Member Services, and urged county societies to speed up their induction process.

**At the finish line**

After "a busy year, a year of preparation, a year of building and planning, a year of new initiative," Dr. Lovette sighed, "I feel a let down now that it is over. It has been an exciting, exhilarating race—a race against time to get everything done, a race that is impossible to win in one year, but one that was a great honor to run."

## Cardiologists admitted

At its 29th Annual Scientific Session, the American College of Cardiology will admit eight Pennsylvania cardiologists to fellowship. This March 1980 meeting in Houston will feature lectures, symposia, discussions, and induction ceremonies.

Robert Zelis, MD, Hershey, ACC governor for Eastern Pennsylvania, announced that the following cardiovascular specialists in the geographic area have achieved the rank of fellowship: John W. Bryfogle, MD, Philadelphia; John M. Burks, MD, Williamsport; Donald C. Durbeck, MD, Shiremanstown; Salvatore P. Girardo, MD, Philadelphia; Jacob Kolff, MD, Philadelphia; and Paul H. Rogers, MD, Phoenixville.

Frederick R. Franke, MD, Pittsburgh, ACC governor for Western Pennsylvania, named the following cardiovascular specialists as fellows: Lawrence A. Bucklew, Jr., MD, Pittsburgh; and William B. Tuttle, MD, Pittsburgh.

## TMI effect on mental health studied

The mental health of residents living in the vicinity of Three Mile Island will be the topic of a study conducted by the Pennsylvania Department of Welfare. Secretary O'Bannon announced that she expects the findings to "extend our rather limited knowledge of the mental health consequences of disasters, and to provide important new data for the global debate on nuclear power."

The study is funded under a federal contract of $375,000 from the National Institute of Mental Health. It will involve interviewing 700 residents within ten miles of Three Mile Island and 350 residents within ten miles of the Shippingport nuclear reactor in Beaver County as a comparison group.

The study will focus on three specific groups within the sample areas: mothers of young children, workers at the plants, and clients of the public mental health system.

## PMS recruiting efforts increase membership

Membership in the State Society as of December 1, 1979 stood at 14,425. Of that number, 10,558 were also AMA members.

Total membership in PMS increased in the past year. From September 30, 1978 to September 30, 1979, 318 physicians joined the Society as active dues paying members and 76 joined as dues exempt members. The rise reflects the recruiting efforts of the Council on Member Services.

The number of PMS members in the AMA also increased in the past year. An additional 324 PMS members joined the AMA in that period.

## Physician pleads guilty on drug charges

James P. Herberg, MD, pleaded guilty November 13, 1979 to twelve counts of drug-related charges in a Juniata County court. Dr. Herberg had practiced medicine in Burnham and also Centre County.

His guilty pleas answered ten counts of delivery of controlled substances and not dispensing controlled substances in good faith, and two counts of conspiring with intent to deliver cocaine.

He is charged in Centre County with six felony counts in connection with prescribing and delivering controlled substances and in Dauphin County, with delivery of a controlled substance.

**DESCRIPTION:** Methyltestosterone is 17$\beta$-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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# Federal court rules Act 111 arbitration must come first

Fred Speaker, Esq.

A federal appeals court recently ruled[1] that plaintiffs in federal court first must go through arbitration under Act 111.[2] This opinion offers small comfort to those who believe in the Act's arbitration process.

The case involved claims by citizens of New Jersey and New York against Pennsylvania physicians and hospitals. The Court of Appeals for the Third Circuit rejected the argument that, because the arbitration process is slow, the plaintiffs will be precluded from a full and fair adjudication in federal court. The Court, however, acknowledged that:

> What we confront is an ambitious state program in which the deed has fallen woefully short of the promise. Of 2,466 claims, only nine have yet reached the hearing stage, the statutory condition precedent to a state court trial. Less than ten percent of the claims have been settled, discontinued, and ended by conciliation conferences, and 507 were dismissed or discontinued without conciliation. Appellants forcefully argue that plaintiffs who have been injured because of medical malpractice have effectively been denied an opportunity to present their cases to a judge and jury. A record that discloses only nine arbitration hearings out of 2,466 claims does not describe a state arbitration system that works exceptionally well, moderately well, or even modestly well. Rather, it describes a system that, though theoretically sound, is actually a resounding flop. Appellants emphasize the patent unfairness of subjecting federal plaintiffs to a state requirement that admittedly fails in its statutory purpose of providing a claimant with "a prompt determination and adjudication of his claim." 40 P.S. § 1301.102. Under these circumstances, it seems onerous, if not futile, to require a federal plaintiff to resort to a state administrative procedure that has proved to be ineffective, inefficient, and incapable of operation under the letter of the statute.[3]

Despite its condemnatory language, the Court upheld the lower courts' refusals to entertain the suits without arbitration on the basis of the doctrine enunciated by the Supreme Court in *Erie*.[4] That doctrine essentially requires federal courts, in diversity of citizenship actions, to apply the substitive law of the state where the incident occurred.

The Court rejected the argument that there are affirmative countervailing federal considerations,[5] and found that Pennsylvania had made clear its interest in the malpractice arbitration system. The Court also found that federal law frequently favors arbitration. The Court stated that:

> Pennsylvania's decision to experiment with arbitration in the medical malpractice context must be respected as a legitimate exercise of state power. This is particularly true given Pennsylvania's common law tradition of trial by jury, which dates back to 1686 and which, in the opinion of the state's highest court, has not been abridged by the arbitration procedure. *Parker v. Children's Hospital,* _____ Pa. _____, 394 A.2d 932, 939-42 (1978).[6]

The Court concluded that:

> In fine, appellants have mounted an argument that is superficially persuasive and appealing, but that should be more properly addressed to the Pennsylvania executive and legislative authorities. Appellants have effectively demonstrated that the state's malpractice arbitration program is in immediate need of drastic restructuring. In describing the program's fundamental deficiencies, they have not demonstrated that it discriminates against non-citizen plaintiffs because the serious deficiencies of the program apply with equal force to citizen plaintiffs.[7]

The benefit of the Court's requirement that arbitration first be held in federal cases appears to be countered by its harsh view about the viability of the arbitration system under Act 111.

1./ *Edelson, et al. v. Soricelli, et al.*, Nos. 78-2627 & 79-1012 (3rd Cir. November 2, 1979).
2./ Health Care Services Malpractice Act, 40 P.S. §§1301.101 *et seq.*
3./ *Edelson, et al. v. Soricelli, et al., supra* at 11-12.
4./ *Erie Railroad v. Tompkins*, 304 U.S. 64 (1938).
5./ See *Byrd v. Blueridge Rural Electric Cooperative, Inc.*, 356 U.S. 525 (1958).
6./ *Edelson, et al. v. Soricelli, et al., supra* at 20.
7./ *Id.* at 22.

## AAFP survey gets 89 percent response

The American Academy of Family Physicians has released data from its most comprehensive survey of active members. The survey shows that:

- 95 percent are engaged in direct patient care
- 33.7 percent are in a rural setting
- 50 percent are Diplomates of the American Board of Family Practice
- 44.3 percent are AAFP Fellows.

The survey was sent in November 1978 to 26,652 U.S.-based active members; 89 percent responded.

Additional analyses were made possible by merging the survey data with the Academy membership files and three files of the Bureau of Health Manpower, DHEW. This combination provided the first data for studying the geographic distribution of the active membership.

The Committee on Research plans a series of surveys to stratified samples of active Academy members to obtain more in depth information on office practice, hospital practice, and professional liability.

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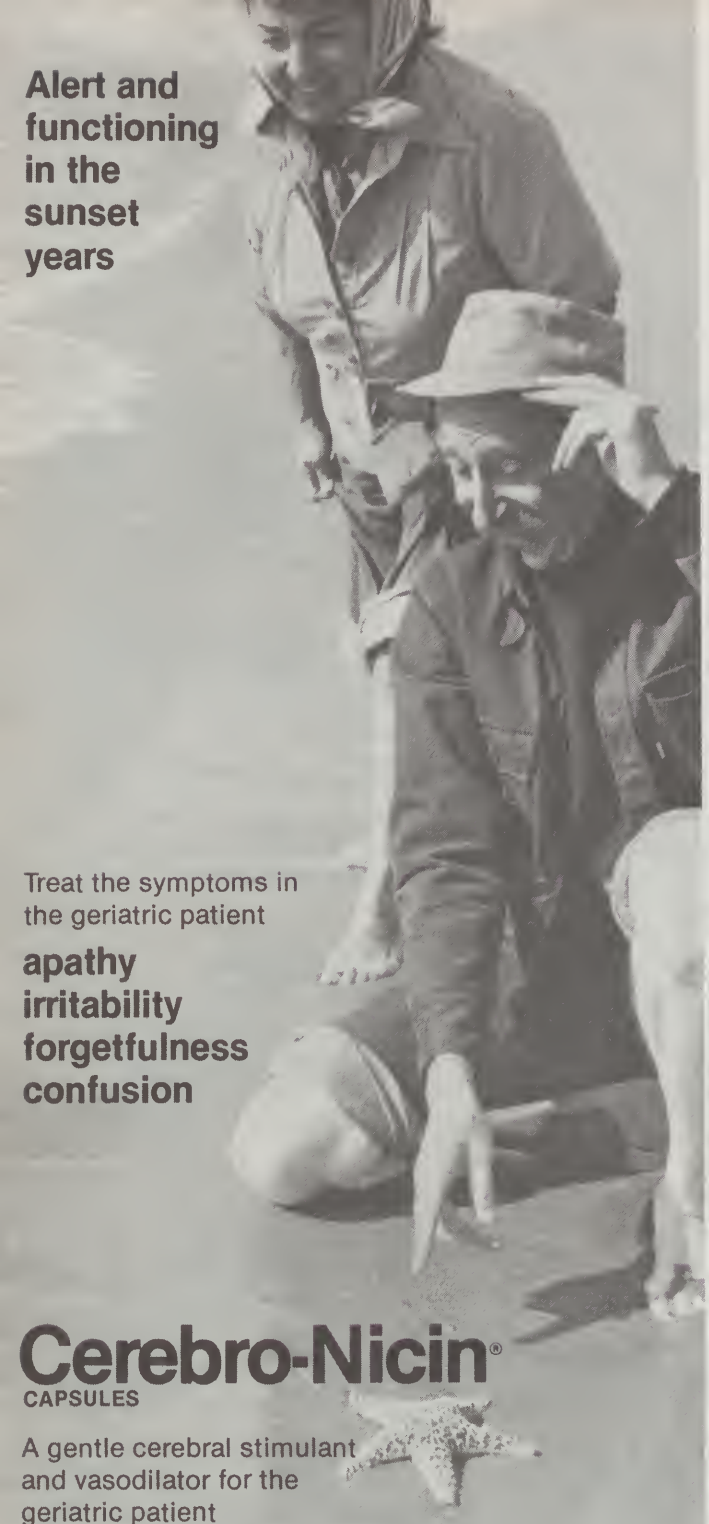
**The 1979-80 Membership Roster is available from the PMS membership department. The Roster contains: component county society officers; component county society members with addresses and specialty codes; and alphabetical roster of Pennsylvania Medical Society members showing county affiliation.**

**According to PMS policy, members may receive a complimentary copy of the Roster upon request. Copies are available for non-members at $30.00 each.**



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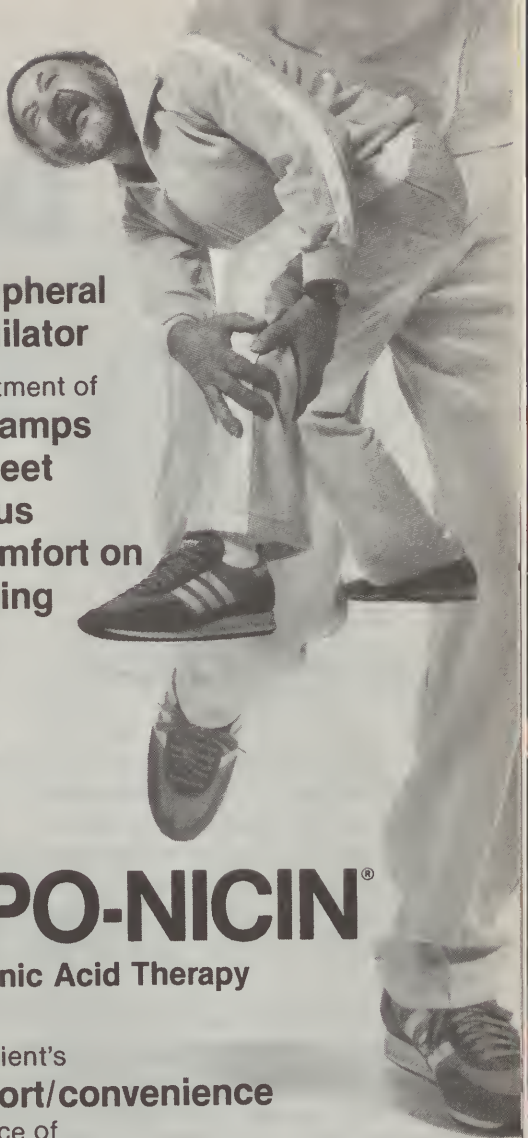

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The National Cancer Institute will provide the "Helping Smokers Quit" kit free of charge to all physicians who want to participate in this important effort. Included in the kit are guidelines for physicians, a self-test to help smoking patients determine why they smoke, pamphlets with tips on quitting, and waiting room posters to introduce the subject. Each kit contains enough materials to help 50 of your smoking patients who want to quit.

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# No fault auto insurance no panacea

Fred Speaker, Esq.

"Caution, anyone who embarks on the high seas of Pennsylvania's No-Fault Motor Vehicle Insurance Act should not do so without a good compass, a knowledge of reefs and storms, and plenty of food and water," advised the Pennsylvania Superior Court. (*Heffner v. Allstate Ins. Co.,* 401 A.2d 1160, 1161, Pa. Super. 1979.)

One section of the statute particularly concerns physicians. This section relates to court accessibility for an aggrieved victim who has failed to reach the $750 threshold in medical expenses.

The provision states that "a person remains liable for damages for non-economic detriment if the accident results in: death or serious and permanent injury." But, what is "serious and permanent injury" according to the courts?

The Pennsylvania Bar Institute analyzed the No-fault Law and considered the phrase in question, saying:

> An injury which is *both* serious *and* permanent will clear the threshold. The plaintiff must prove that it is *probable,* based on the preponderance of the evidence, that the injury will be permanent. The question of seriousness . . . will possibly be more difficult to determine and more varied since common sense would indicate that the determination of "seriousness" would vary as respects the victim's lifestyle, bodily functions, or work requirements. It is likely that the serious and permanent injury test will be rarely used because it is hard to conceive of very many serious and permanent injuries where the monetary threshold would not be satisfied. PBI, "Pennsylvania No-fault Motor Vehicle Insurance Act - Practice under the Act" pp. 93-4 (Pub. #61, 1975).

To our knowledge, the first court that considered the specific meaning of "serious and permanent injury" was the Bucks County Court of Common Pleas in *Bromiley v. Collins,* 1 D&C3d 94 (Bucks 1977). In that case the plaintiff alleged that she had suffered serious and permanent injuries, including contusions of the forehead, lacerations of the upper lip, cervical sprain, bruises and various abrasions, severe damage to her nerves and nervous system, and other ills. (*Id.* at 98.)

The court agreed with the defendant that the plaintiff's claim was deficient. The court stated:

> In dealing with the problem raised by defendant, we find ourselves . . . attempting to set forth how an allegation should be worded and what such an allegation should include in order to qualify as crossing the threshold from no-fault recovery to traditional tort law damages . . . we have great difficulty in concluding that the bald assertion that the injuries enumerated . . . were "serious and permanent" is any more a sufficient averment than would be the mere legal conclusion that such injuries qualified under section 1009.301 (5) (A) of the Act.
>
> . . . even if specific injuries are pleaded and each is labeled as to whether or not that injury is serious and permanent, or results in cosmetic disfigurement, we still do not believe, under the rationale of the No-fault Act, i.e. expeditious handling of injury claims, that such a pleading should suffice. . . .
>
> It is plaintiff's burden to plead those "ultimate facts" which are essential to prove his claim: *Baker v. Rangos,* 229 Pa. Superior Ct. 333, 324 A. 2d 498 (1974) . . .
>
> . . . why should plaintiff not be required to plead with specificity the injuries which have been sustained, and not merely the conclusion that the injuries are serious and permanent? *Certainly, the burden of proof would rest on plaintiff so to establish that aspect of his case at the time of trial, and this could be accomplished only by expert testimony from one schooled in medicine, unless the very nature of the injury made it evident that the injury was serious and permanent, e.g., the loss of a limb.*

Thus it appears that "serious and permanent injuries" are those which a physician will so testify or are those which are obvious. The No-fault Law does not contain a definition of the meaning of the term; therefore, if we are to look to statutes for help in definition, we must look elsewhere.

The Pennsylvania Crimes Code, 18 C.Pa.S. §§101 *et seq.,* contains a provision which uses the term "serious bodily injury" and defines it as: "bodily injury which creates a substantial risk of death or which causes serious, permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ." 18 C.Pa.S. §1903(a).

Beyond a statutory definition of the phrase "serious and permanent injury," we must consider the common usage of "serious." The General Assembly provided in the Statutory Construction Act of 1972, that "words and phrases shall be construed according to rules of grammar and according to their common and approved usage." 1 C. Pa.S. §1903(a).

*The American Heritage Dictionary of the English Language* (1969), defines "serious" as "grave in character, quality, or mien" or "concerned with important rather than trivial matters." *Id.* at 1184.

In summary, it appears that the meaning of the phrase will be determined by a judge or a trier of the facts, and that substantial evidence of whether an injury is "serious" will depend on the testimony of a physician or upon observation of the injury which determines that it is clearly grave or important.

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton & Scheetz, which serves as the State Society's legal counsel.*

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# physicians in the news

**Ian S.E. Gibbons, MD,** has been named medical director of Children's Heart Hospital. Dr. Gibbons is clinical professor of pediatrics and director of the division of pediatric gastroenterology and nutrition at Thomas Jefferson University.

As outstanding clinical teacher this year, **Benjamin E. Price, MD,** received the Russell P. Moses Award at Temple University School of Medicine. Dr. Price is assistant professor of pediatrics and coordinator of the primary care medicine course for freshmen at the school.

**George Manstein, MD,** has been elected to the board of directors of Philadelphia Geriatric Center. Dr. Manstein is chairman of the department of plastic surgery at the Albert Einstein Medical Center and associate professor of plastic surgery at Temple University School of Medicine.

Warren County recently honored **Khlar McDonald, MD,** with the Community Service Award of the Chamber of Commerce. Dr. McDonald, a thirty third degree Mason, was cited for his activities in Scouting, the United Way, and borough government.

New officers were elected at the recent meeting of the Northeastern Pennsylvania Psychiatric Society in Wilkes-Barre. **Steven R. Kafrissen, MD,** was elected president; **Guido Boriosi, MD,** vice president; and **Gene Haring, MD,** secretary-treasurer.

**Benjamin A. Hoover, II, MD,** has been named president of the Rotary Club of York. Dr. Hoover is a third generation Rotary Club president. His father and grandfather, both physicians, served as presidents of their community Rotary clubs.

**Harry Williams, MD,** Elkland, received recognition for his efforts for the benefit of his community as county coroner. The Tioga County Medical Society awarded Dr. Williams a plaque to commemorate his 36 years of service at that post.

**Evan G. Pattishall, Jr., MD,** associate provost for health education and professor and chairman of the department of behavioral science at Penn State's College of Medicine, has been named interim dean of the University's College of Human Development. Dr. Pattishall has been a pioneer in establishing behavioral science as an integral part of medical education.

Grove City College Alumni Association honored **Garrett C. McCandless, MD,** with its achievement award. Dr. Garrett graduated from Grove City in 1923 and began serving as a physician for the Franklin community in 1932. **Stephen D. Lockey, MD,** received an alumni citation from the Franklin and Marshall College Alumni Association. Dr. Lockey, a 1928 graduate of the college, is a specialist in allergy and immunology.

**John H. Esbenshade, Jr., MD,** has been named to the Temple University board as a Commonwealth trustee for a one-year term. Dr. Esbenshade is director of medical education, senior physician, and senior cardiologist at Lancaster General Hospital.

The American Medical Student Association honored **Harris Clearfield, MD,** and **Leslie Rose, MD,** with Golden Apple Awards for teaching excellence at the Hahnemann Medical College and Hospital of Philadelphia. Dr. Clearfield is professor of medicine and director of the gastroenterology division; he also received the Lindbach Foundation Award for excellence in teaching. Dr. Rose is professor of medicine and director of endocrinology and metabolism.

**Mary Ellen Smith, MD,** Lancaster, received the annual award of the Commonwealth Board of the Medical College of Pennsylvania at its recent meeting in Harrisburg.

The award recognized Dr. Smith's voluntary efforts to guard the health of the children in her community by conducting physical examinations in the Lancaster City and Salanco schools. Dr. Smith also served as part-time physician for Millersville State College.

She has been active in the Lancaster City and County Medical Society. Dr. Smith married a physician. She was president of the Lancaster City and County Medical Society Auxiliary and a member of the Board of Directors of the Pennsylvania Medical Society Auxiliary.

Officers of the Pennsylvania Society of Anesthesiologists PSA for 1979-80 are **Stephen C. Finestone, MD,** president, **Allen Yeakel, MD,** secretary, and **Donald Wentzler, MD,** treasurer. PSA officers and members celebrated the recent success of their national society, the American Society of Anesthesiologists, in its defense against the Justice Department's attack on its relative value guide.

DR. FINESTONE

DR. YEAKEL

**Mary B. Dratman, MD,** has been elected to the board of corporators of the Medical College of Pennsylvania. Dr. Dratman is professor of medicine in the endocrinology section at MCP and medical investigator at the Veterans Administration Hospital, Philadelphia.

DR. DRATMAN

DR. CLIFFORD

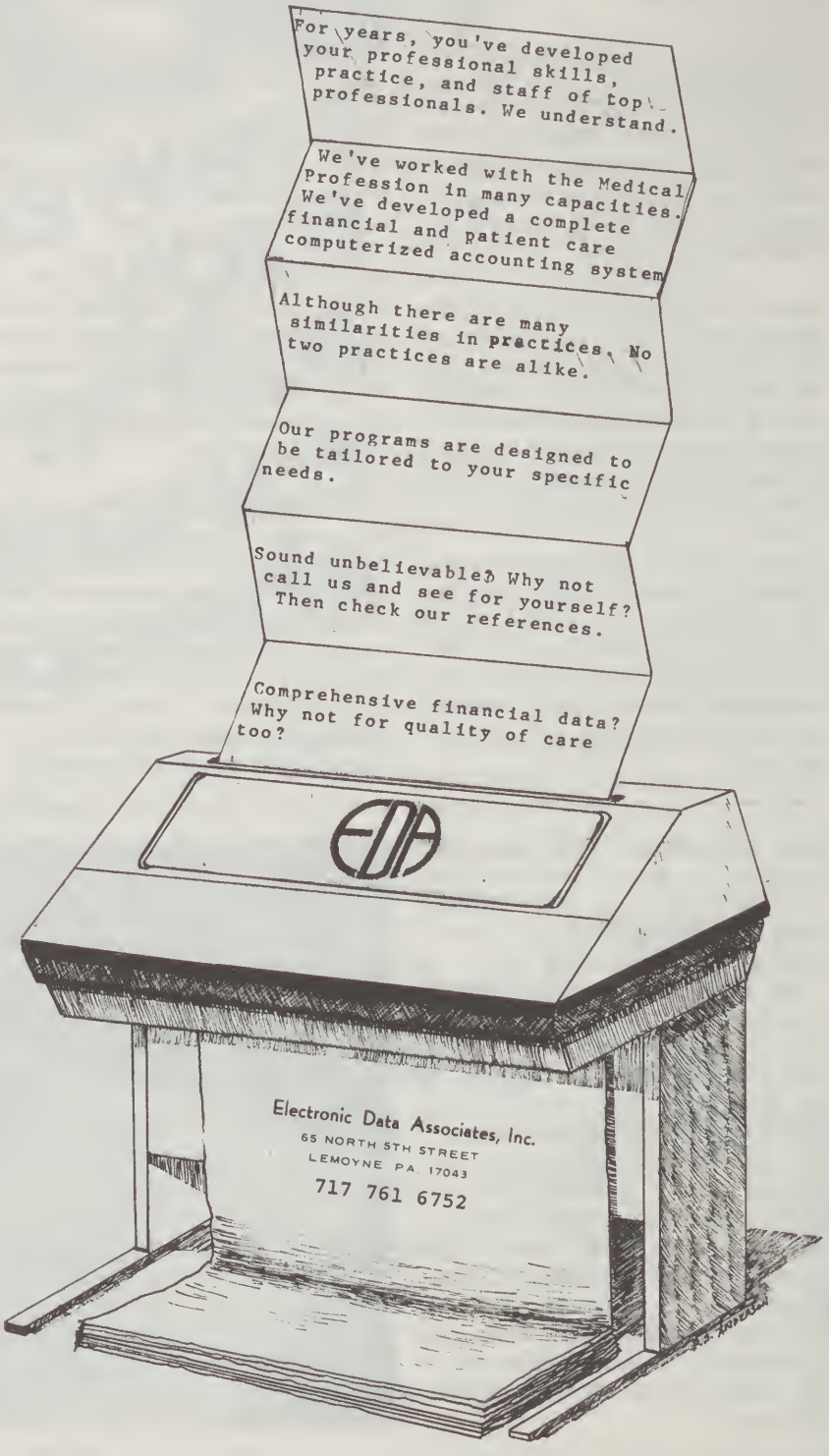
**Maurice C. Clifford, MD,** has been appointed vice president for medical affairs as chief executive officer at the Medical College of Pennsylvania. Dr. Clifford, clinical associate professor of obstetrics and gynecology, has been on the faculty since 1955.

Geisinger Medical Center President **Henry Hood, MD,** announced three executive promotions at a recent quarterly meeting of the board of directors. **Kenneth E. Quickel, Jr., MD,** was appointed executive vice president, and **Thomas Royer, MD,** was named vice president and associate medical director.

**Giulio J. D'Angio, MD,** recently received the 14th annual Health Memorial Award for outstanding contributions to the care of cancer patients. The award was presented by the University of Texas M.D. Anderson Hospital and Tumor Institute. Dr. D'Angio, a leading pediatric radiotherapist, is the director of the Children's Cancer Research Center at the Children's Hospital of Philadelphia.

The Congress of Neurological Surgeons has honored **William A. Buchheit, MD,** professor and chairman of neurosurgery at Temple University Health Science Center. Dr. Buchheit was cited for his exceptional and distinguished service.

**Charles Umlauf, MD,** Emmaus, has been elected treasurer of the American Board of EEG, Inc. Dr. Umlauf is chief of Allentown Hospital's psychiatry department.

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**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

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- Pennsylvania Medical Care Foundation

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Physician Placement Service
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Speech writing service
Public relations counsel
Free health education pamphlets
Medical Benevolence Fund
Medical Education Resource Center
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## PMS and AMA membership classifications

**Active member**—Any member who holds an unrestricted license to practice medicine and surgery in Pennsylvania. Also includes all federally (civilian and military) employed physicians (licensed and unlicensed). Active members must meet the continuing education requirement.
Dues: *PMS—$225.00
*AMA—$250.00 (AMA dues may be excused if over age 70).
Benefits: PMS—All
AMA—All except publications for AMA dues exempt are available only by subscription.

*Military*—Any active member serving temporarily in the armed forces or other federal government service (before March 1).
Dues: PMS—Dues-exempt
AMA—$35.00
Benefits: PMS and AMA—All

*Disability*—Any active member who is prevented from the practice of medicine by reason of illness or disability.
Dues: PMS and AMA—Dues-exempt
Benefits: PMS—All
AMA—Same as AMA dues exempt above

*Intern and Resident*—Any member serving an accredited hospital internship, residency, or other recognized full-time postgraduate training.
Dues: PMS—$22.50 (10% of regular assessment)
AMA—$35.00
Benefits: PMS and AMA—All

*Senior*—Any active member at least 65 years of age on January 1 with at least 30 years continuous membership (membership in other states or AMA may be included).
Dues: PMS—$112.50 (50% of regular assessment)
AMA—$250.00 (AMA dues may be excused if over age 70).
Benefits: PMS—All
AMA—Same as active member except publications for AMA dues exempt are available only by subscription.

*Associate*—Any active or senior active member who is at least 70 years of age and who has at least 30 years continuous membership (membership in other states or AMA may be included).
Dues: PMS and AMA—Dues-exempt
Benefits: PMS—All.
AMA—All, except dues exempt will not receive scientific publications except by direct subscription.

**Affiliate member**—Any member of a component society not engaged in active practice within the jurisdiction of the component society who belongs to one of the following classes:
- Members of national medical societies or foreign countries;
- American physicians whether or not licensed to practice medicine and surgery in Pennsylvania engaged in missionary or philanthropic labors;
- Full-time teachers of medicine or of the arts and sciences allied to medicine who are not holders of an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania;
- Physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research or administrative medicine;
- Physicians, whether or not fully licensed to practice medicine in Pennsylvania, who are retired from active practice;
- Physicians in active practice who move out of the Commonwealth of Pennsylvania if they maintain active membership in a county society and the state society in their new state of residence. Members in this category are not eligible for any Society-endorsed insurance programs.

Dues: PMS and AMA—Dues-exempt
Benefits: PMS—cannot vote or hold any office, serve as a delegate, member of a commission, committee, or council, and is not entitled to benefits of Medical Benevolence Fund or Educational Fund.
AMA—Same as Associate Member

**First calendar year of active practice PMS and AMA dues are 50 percent of active member dues.*

# Blue Shield payment mechanism explained

The PMS Council on Medical Economics hopes with this article to enlighten readers who do not understand the method used by Pennsylvania Blue Shield to arrive at the fees which physicians receive for services.

The usual, customary, and reasonable (UCR) payment mechanism used by Pennsylvania Blue Shield (PBS) was developed to provide equitable payment for physicians' services and paid-in-full benefits for subscribers at predictable cost. This payment system functions on the basis of three criteria: usual, customary, or reasonable charges.

Terminology varies between PBS's Prevailing Fee Program and Medicare Part B. To operate the system Blue Shield's staff uses the simplified terms, Level I and Level II. Table 1 shows a comparison of these different terms.

**Usual (Level I)**

A Usual (Level I) charge is the fee which an individual doctor most frequently charges to patients for the procedure performed. This is the first charge against which a claim charge is measured. It is determined from actual charges reported to PBS on Doctors Service Report forms, CHAMPUS claims, and for Medicare Part B on the Request for Medicare Payment forms, statements, and receipted bills.

Presently, Level I charges are established at the 75th percentile charge reported on claims submitted during calendar year 1978. See Figure 1 for an example of a calculated Level I charge.

**Customary (Level II)**

A customary (Level II) charge is determined using the range of usual fees charged by physicians of the same specialty in a given geographic classification for the procedure performed. These geographic areas are defined in terms of the hospital service areas established by the Pennsylvania public welfare department.

Table II gives the necessary data to calculate a customary (Level II) charge. In this example the 90th percentile is $20, the amount at which 90 percent or more of the charges in the array fall below that point.

Medicare Part B does not use the same methods to determine Level I and Level II charges. According to Medicare, Level I is determined by the

**TABLE I**
**Comparable Terms**

| *PBS Prevailing Fee Program* | *Medicare Part B* | *Simplified* |
|---|---|---|
| Usual charge | Customary charge | Level I |
| Customary charge | Prevailing charge | Level II |

**TABLE II**
**Data for Level II**

| *Usual charge (Level I)* | *Frequency of charge* | *Cumulative total by specialty* | *Cumulative percent* |
|---|---|---|---|
| $10 | 40 | 40 | 10% |
| 12 | 44 | 84 | 21 |
| 15 | 160 | 244 | 61 |
| 20* | 120 | 364 | 91 |
| 25 | 25 | 388 | 97 |
| 30 | 12 | 400 | 100 |

* *Customary charge (Level II)*

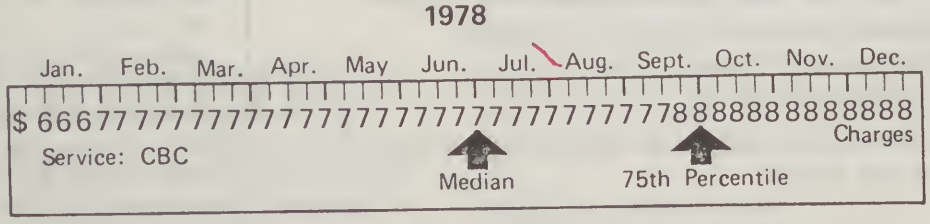


*Figure 1.* **Level I charge established at the 75th percentile shows $8 charge for CBC.**

**TABLE III**
**UCR Payment Chart**

| *Procedure code* | *Physician's claim* | *Usual charge (Level I)* | *Customary charge (Level II)* | *PBS payment* |
|---|---|---|---|---|
| 21681 | $25 | $25 | $50 | $25 (usual) |
| 21971 | 25 | 25 | 20 | 20 (customary) |
| 21974 | 25 | 10 | 20 | 25 (reasonable) |

median (see Figure 1), and the Medicare Level II charge is established at the 75th percentile.

**Reasonable**

The reasonable criterion permits individual consideration for cases with unusual clinical circumstances. The fee, which differs from the usual or customary charges, reflects the additional time, skills, and experience necessary to handle the medical complications.

**UCR payment mechanism**

In the absence of unusual circumstances, PBS determines UCR payment by following these steps:

1. Check each reported charge against the usual charge of record (Level I) in the individual physician's profile to verify it is his usual charge.
2. Check each reported charge and the usual (Level I) against the customary charge (Level II) for the procedure in the physician's specialty and geographic area. Unless unusual circumstances are reported, the customary charge is the maximum that can be paid.
3. Pay the lesser of the reported charge, the Level I or the Level II.

When the reasonable criterion applies, the following steps are taken:

1. Review to check that the Doctors Service Report contains a description of unusual circumstances.
2. Correspondence with the physician to permit supply of additional information from records.
3. Review by a PBS medical advisor whose specialty encompasses the reported procedure.
4. Referral to an appropriate peer review committee. (The arrangements for submitting claims to peer review are described in the Peer Review section of the Pennsylvania Blue Shield Procedure Terminology Manual beginning on page 58.)

Table III charts the UCR payment mechanism for three different procedures. Note that in the second procedure, code 21971, PBS pays only $20, since the customary charge is less than the usual charge. In the third procedure, code 21974, the physician substantiated unusual clinical circumstances, and the reasonable criterion was applied.

**Profile**

A profile is PBS's record of fees on file for each individual physician or other service provider. PBS and Medicare do not adjust automatically the physician's profile when his charges change. For its own business and Medicare Part B, PBS conducts an annual revision of all profiles usually on July 1. Adjustments are based on the previous calendar year's experience. Thus, the actual charges reported on claims during 1978 were used to calculate a profile for July 1, 1979. Each year the Pennsylvania Insurance Department must approve the revisions for PBS business and the Health Care Financing Administration (HCFA) must approve the revisions for Medicare before they become effective.


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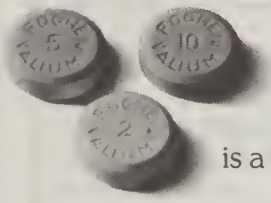


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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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John Watkins, M.D. — Janis E. Zvargulis, M.D.

**10:30 - 10:45** Coffee

**10:45 - 12:15** Panel on *MEDICAL VS SURGICAL JAUNDICE*

Moderator: Ralph M. Myerson, M.D.

Martin Black, M.D. — John R. Senior, M.D.
George L. Popky, M.D. — Roger D. Soloway, M.D.

**12:15 - 1:30** Luncheon

**1:30 - 3:00** Panel on *DIARRHEA AND MALABSORPTION*

Moderator: Walter Rubin, M.D.

Frank P. Brooks, M.D. — Steven Nussbaum, M.D.
O. D. Kowlessar, M.D. — James L. A. Roth, M.D.

**3:00 - 3:15** Coffee and Coke

**3:15 - 4:45** Panel on *PERIANAL PROBLEMS*

Moderator: Harris R. Clearfield, M.D.

Julius J. Deren, M.D. — Julian Katz, M.D.
Harry J. Hurley, M.D. — Harold Rovner, M.D.

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# editorial

## A decade dawns

January of 1980 brings the debut of a new decade for medicine and for the world. The previous decade brought more than its share of surprises and disillusions. To speculate on the nature of the changes that will occur in the 1980s might be viewed with trepidation or anticipation, depending upon your personal bias.

The seventies manifested continued rise in the inflation rate, with practically all governmental attempts to curb it proving futile.

Political disillusion reached its peak with the resignation of a president and the downfall of his administration. Each subsequent trial and conviction of an elected public official, including Pennsylvanians, fortified the cynicism of the people.

Pennsylvania found itself in the international spotlight when a nuclear accident occurred near the state capitol. Although individuals who dealt with the reactor problem stand in high esteem, the government agency responsible for licensing nuclear facilities, the Nuclear Regulatory Commission, is viewed with considerable distrust. In short, Americans do not appear to hold either elected or appointed governmental officials in worshipful repute.

While the domestic record seems to be in shambles, the foreign affairs program has met with a number of shining successes. The end of the Viet Nam war and the draft established a domestic tranquility Americans had not experienced in over a decade. The official recognition of China and the Israel-Egypt peace negotiations represent landmark achievements which would not have been possible without strong American leadership.

Medicine, too, has had its share of difficulty as well as achievement. The malpractice crisis plagued physicians and hospitals over the entire decade. The press has made hay over medicare and medicaid fraud, quackery, and laetrile.

On the positive side, medicine has met the need for more primary care physicians by increasing post-graduate education programs in this area. The birth of the first "test-tube" baby was a medical milestone. And in one of the most dramatic advances in medical science, the computed tomographic scanner was developed. The marvel of this development was recognized when its two pioneering researchers received the Nobel Prize in Medicine in 1979.

Will the 1980s be any different? We can expect an equal number of successes and disappointments. Medical technology will continue to improve but the question of cost will enter into its development and widespread implementation. Medical costs loom as a major issue for the new decade. Testing new, less costly methods of delivery of health care will demand more time. Perhaps we will see more emphasis on preventive medicine and a greater awareness of the need for physical fitness.

Our responsibility is to maintain and improve the quality of medical care and the quality of life as economically as possible. We need to be politically attentive. Our careful selection and support of candidates in the upcoming presidential election will decide numerous aspects of the course of medicine in the next ten years and beyond.

As socioeconomic problems such as unemployment and inflation grow, the governmental urge to tinker with the current medical system will increase. The medical profession must be prepared to participate, both directly and through amicable legislators, in any decisions that ultimately affect the health of the American people. If we do not insure quality of care for all the people, the medical advances that have been achieved will have been for nothing.

David A. Smith, MD
Medical Editor

# in my opinion

### More on NHI

Dr. Paul S. Friedman, writing in the October issue of PENNSYLVANIA MEDICINE, asks "Do we need national health insurance?"

While Dr. Friedman makes some valid points, he repeats arguments that have been made for a full generation. These arguments, in my opinion, leave some significant hiatuses.

Dr. Friedman states, "With the advent of medicare and medicaid, adequacy and access were provided." As far as medicaid is concerned, in Pennsylvania at least, it is neither adequate nor accessible. And we are told that Pennsylvania is one of the more progressive states in this regard! To provide access to medicaid, there is a state bureaucracy. The bureaucracy establishes and constantly reviews eligibility. When the client's income perchance rises above subsistence level, the bureaucracy denies access.

Nationwide, some twenty million people have no medical insurance coverage. Generally, these people with no private sector insurance coverage are either not quite poor enough to qualify for paupers' aid, or, if eligible, not informed enough to gain access to it. This same element of the population is the most vulnerable to illness and is generally least able to apply the political and economic clout to secure its interests.

As to the adequacy of medicaid benefits, Pennsylvania medicaid simply must be regarded as second rate medical care, and likely to become worse. The laboratory services arbitrarily chosen for payment by this insurance are grossly inadequate to provide modern diagnostic workup, or laboratory follow-up of therapy, for any but the simplest problems.

Modern advances in medicine such as pulmonary func-

tion and ultrasound are excluded, and the *only* test available to establish or follow any endocrine disease is the blood glucose. No hematologic studies except the misnamed complete blood count can be ordered in a clinic setting for medicaid clients.

The poor do without studies available to the rest of us; or perhaps hospitals absorb the cost (i.e., pass them on to the insured); or, as Temple University Hospital nearly did a few years ago, face bankruptcy in caring for the poor. Usually the poor are told callously to pay for tests out of their meager DPA doles (calculated to pay for subsistence food and shelter only).

Dr. Friedman proposes a "system of uniform medical benefits for persons unable to provide for their own medical care." Uniform as measured by what? Present Pennsylvania medicaid benefits are uniform, and grossly inadequate. If Dr. Friedman means the same benefits available to high option Blue Cross, I would agree.

As to priorities, any system of tax-subsidized medical insurance must consider that providing the popular goal of catastrophic health insurance means increased insurance benefits for people already covered by basic insurance. In fairness, this should take second place to providing *basic* health insurance to *all* citizens. Yet, this "catastrophic" insurance, probably because of its appeal to the politically active middle classes has more advocates than has providing basic health insurance protection for all citizens.

Only when our system can provide everyone with the quality of care made possible by modern advances in medicine can we be satisfied that social justice has been achieved. Maybe then we can adopt a legitimate critical attitude toward the health care problems of other countries.

Perhaps as Dr. Friedman suggests, we do not need national health insurance. But how long can we wait for the alternative?

Robert C. Wolfe, MD
Philadelphia

## Fears fear in insurance sales

A letter I recently wrote may generate some discussion about the troublesome proliferation of limited disease-oriented insurances. The letter, which follows, responds to a national company's efforts to solicit money for a cancer expense protection and cancer insurance plan.

"I have just received your offer of cancer insurance. I, and the medical profession in general, strongly object to disease oriented insurance coverage.

"The appropriate health insurance policies now generally available provide adequate coverage for cancer and all other catastrophic diseases.

"Your solicitation of money for cancer insurance is both unethical and duplicitous.

"For individuals without adequate health plans, cancer insurance potentially shunts money from the purchase of comprehensive plans to limited disease entity plans such as yours, leaving the buyers with less protection ultimately. It also duplicates coverage already available for purchasers of adequate health plans.

"It is clear that cancer insurance takes advantage of the fears and misconceptions of the public regarding this disease and the nature of adequate health care and health insurance in general.

"The efforts of your company and of others that offer cancer insurance would be better directed towards offering improved comprehensive health plans."

Eli Goodman, MD
Philadelphia

## NAPS Syndrome

The house lights dim, the introduction ends, the topic is announced, and the first slide flashes on the screen. Then the moderator makes his first mistake — he hands the speaker the electric arrow pointer. This is the etiology of the Nervous Arrow Pointing Speaker Syndrome.

To keep my thoughts logical, I have divided the light wand users into several separate groups.

First there are are the circular doodlers — a breed addicted to encircling figures and headings on the screen with lighted circles. The main danger here is the possibility of precipitating an oculogyral crisis.

The second group of speakers belongs to the 'Underline with Light' school. Back and forth that arrow goes, underlining everything on the slide. Here one needs to guard against vertigo with a horizontal nystagmus.

Third are speakers who use the light in a vertical fashion. They sometimes appear to be sewing and at other times may seem to pound nails. Watching these pointers leads to eye fatigue and headaches. Speakers who use this pointer movement often note nodding heads in the audience (their listeners following the pointer), and mistakenly assume that the talk is going over very well.

Several other groups of pointer presenters might be mentioned just in passing. There are, for example, the light artists. Like Picasso, they draw artistic designs in the darkened lecture room with their pointers. It is a pity some of these light drawings cannot be preserved. I once attended a lecture where several of the members of the audience were stabbed with the light beam and, although there were no serious injuries, one attendee did complain that he saw spots for some time after the incident. And, finally, we have the wall wanderers, the ceiling circlers, and the floor fanners.

What, then, can be done to correct this increasing epidemic of irresponsible and distracting pointer usage? We might design a course on "Light Etiquette, A Guide to Effective Pointing," but that probably would not attract many participants. Maybe at the beginning of the lecture we could supply a pointer equipped with weak batteries. When we determined how well the speaker will handle it, we could have the moderator replace the batteries with fresh ones.

The only other alternative is to go to the legislature with a bill to ban irresponsible pointer usage. If that seems silly to you, maybe you ought to examine some of the bills which *really* are brought to vote.

Well, the house lights are up again and that lecture on "Anaerobic Nutrition of the Neurotrophic Axon Sheath in Caged Kangaroos Under Stress" is completed. My, but my eyes sting — I simply must get them checked soon.

J. Mostyn Davis, MD
Shamokin

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**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

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# obituaries

*• Indicates membership in the Pennsylvania Society at time of death*

• **Max Abram Antis,** Pittsburgh; Jefferson Medical College, 1931; age 72, died November 10, 1979. Dr. Antis was in private practice in Pittsburgh for 40 years.

• **Oscar Vivian Batson,** Philadelphia; St. Louis University School of Medicine, 1920; age 85, died November 11, 1979. Dr. Batson was an emeritus professor of anatomy at the University of Pennsylvania.

• **Samuel Thomas Ceraso,** Vandergrift; Jefferson Medical College, 1943; age 62, died November 12, 1979. Dr. Ceraso was a general practitioner in his community for many years.

• **Arthur W. Clateman,** Lauder Hill, Florida; George Washington University School of Medicine, 1942; age 63, died November 3, 1979.

• **Lewis Elmer Etter,** Warrendale; University of Pittsburgh School of Medicine, 1927; age 79, died October 29, 1979. Dr. Etter, radiologist and educator, practiced privately in Warrendale for 50 years.

• **August C. Pavlatos,** Lancaster; University of Maryland School of Medicine, 1937; age 69, died November 1, 1979. Dr. Pavlatos practiced in the Lancaster area for more than 40 years.

• **Leonard Lawrence Radnor,** Pittsburgh; University of Pittsburgh School of Medicine, 1955; age 51, died November 18, 1979.

• **Robert F. Rohm,** Carnegie; University of Maryland School of Medicine, 1931; age 72, died November 13, 1979.

• **George Anthony Tushim,** Mill Hall; Temple University School of Medicine, 1969; age 37, died November 7, 1979. Dr. Tushim was chief of employe health and former chief of the emergency room at Lock Haven Hospital. He was a charter member of the American College of Emergency Room Physicians and also past president of Clinton County Medical Society.

• **Martha Ellen Southard,** Philadelphia; Ohio State University College of Medicine, 1947; age 57, died October 21, 1979. Dr. Southard was a professor of radiation therapy and nuclear medicine at Thomas Jefferson University.

• **Angelo M. Zosa,** Wyncote; University of Santo Tomas, Philippines, 1960; age 41, died November 25, 1979. Dr. Zosa was a psychiatrist. He was director of the Montgomery County Mental Health-Mental Retardation Emergency Service and an assistant professor of psychiatry at Temple University School of Medicine.

**John J. Anastasia,** Lower Pottsgrove; Hahnemann Medical College, 1937; age 70, died October 18, 1979. Dr. Anastasia served as chief of physical medicine and rehabilitation at the VA hospital in Coatesville for 20 years.

**Esmond R. Long, Sr.,** Philadelphia; Rush Medical College, 1926; age 89, died November 11, 1979. Dr. Long received the Philadelphia Bok Award for his work in tuberculosis control and was a past president of the National Tuberculosis Association.


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# Sarcoidosis: rare cause of superior vena caval obstruction

Evlin L. Kinney, MD
Revathy Murthy, MD
Gil Ascunce, MD
Kalpalatha K. Guntapalli, MD
Robert Zelis, MD

Sarcoidosis is an unusual cause of superior vena caval obstruction (SVCO). It has been reported only once previously. We now report another case.

## Case report

A 23-year-old black female was admitted to the District of Columbia Hospital in January 1975 because of an abnormal chest x-ray.

Six months prior to admission, pleuritic chest pain and dyspnea occurred but subsided spontaneously in a half week. Three months later, she developed a cough, producing yellow sputum; the pleuritic chest pain returned. Two weeks prior to admission she noted swelling of the breasts and the neck.

Physical examination revealed jugular venous distention, more in the right neck than in the left. There was edema over the right half of the face and in the right neck. Abnormal cutaneous veins and pitting edema were not present on the chest wall. Examination of the thorax revealed dullness to percussion and rales over the isthmus of Krönig.

By chest radiograph, there was a coarse reticular infiltrate in the right upper lobe and a right paratracheal mass (Figure 1).

Three days after a non-diagnostic mediastinoscopy, both arms became edematous and the cephalic veins appeared to be engorged. Mild swelling of the chest wall also was noted for the first time. The arm and chest wall edema became more pronounced over the next four days, at which time bilateral brachial venograms were performed. Bilateral subclavian obstruction and numerous collateral vessels were demonstrated.

*Figure 1.* **Chest x-ray shows a coarse reticular infiltrate in the right upper lobe and a right paratracheal mass.**

Because the SVCS still was suspected to be a malignancy, the patient underwent a right thoracotomy. At surgery, a bulky mass was found, extending from the chest wall into the lung, containing considerable fibrosis and confluent, non-caseating, epithelioid granulomas (Figure 2).

Six days after surgery, the left neck was found to be swollen, red, and hot. The jugular venous distention also had increased. The breasts were extremely edematous. During the next week, the breast and arm swelling gradually resolved spontaneously and the patient was discharged.

During a three-year observation period, the patient continued to feel good, except for sarcoid parotitis from March to May 1975, and mild, intermittent neck swelling. She never has received corticosteroids.

*Drs. Kinney and Zelis are from the division of cardiology at the Hershey Medical Center. Drs. Murthy, Ascunce, and Guntapalli are from the District of Columbia General Hospital, Georgetown University division.*

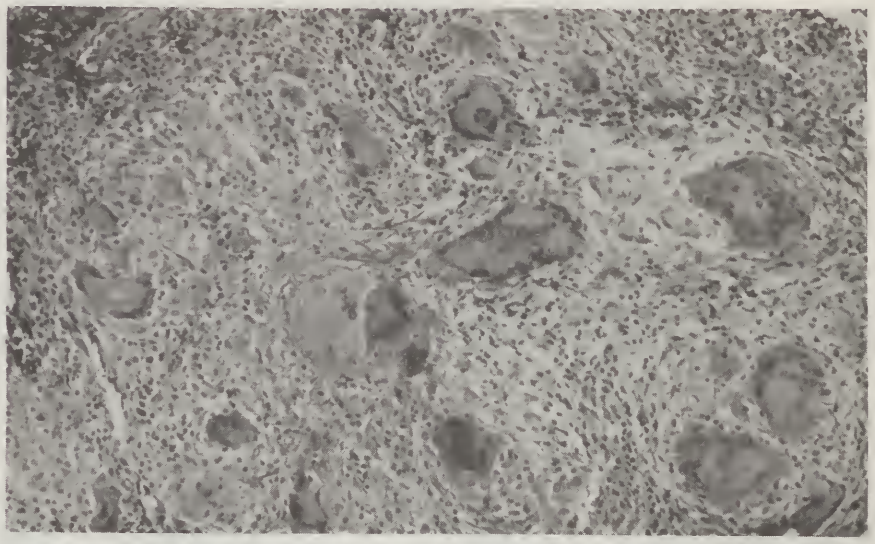

*Figure 2.* **Histopathologic section from the lung shows confluent, non-caseating, epithelioid granulomas, and fibrosis.**

## Discussion

Although involvement of mediastinal lymph nodes is perhaps the most common manifestation of sarcoidosis, it has been reported as a cause of superior vena caval obstruction only once previously.[1]

The differential diagnosis of this patient, were it not for her superior vena caval obstruction, would have given a prominent place to sarcoidosis. She is young, black, female, and her chest radiograph looked dramatically worse than her symptoms. Because of the signs and symptoms of caval obstruction, however, mediastinoscopy was attempted, with worsening obstructive symptoms. To our knowledge, this complication of mediastinoscopy has not been reported previously.

Our patient has not been treated with corticosteroids. Still, in the past three years she has shown a gradual remission in her obstructive symptoms. Superior vena caval obstruction due to sarcoidosis has been an indolent disease in both our patient as well as in the previously reported case. More such cases need to be reported before its natural history can be determined. □

## REFERENCES

1. Gordonson, J., Trachtenberg, S., Sargent, E.N.: Superior vena cava obstruction due to sarcoidosis. *Chest 63*:293-293, 1973.

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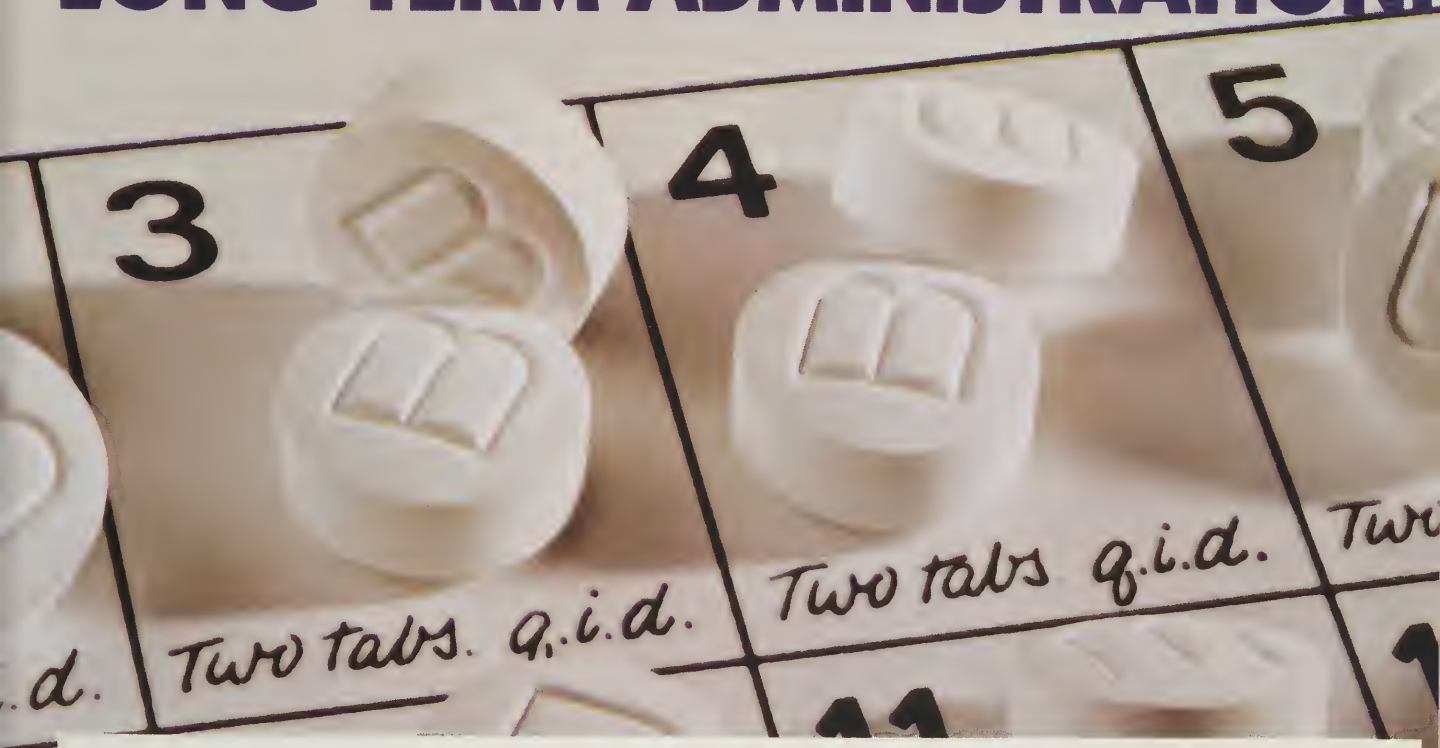

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**Dosage and Administration:** *Adults:* Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg./ml., but not to exceed 20 mcg./ml.

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- Bioavailability equal to an elixir[1]
- Achieves blood levels rapidly[1]

[1] Tinkelman, D.G., Carroll, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. Medical Challenge 10:24-26, 1978

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# Surgically proven accuracy of cholecystoechography

Anthony J. Comerota, MD
John Breckenridge, MD
Willis P. Maier, MD

The established procedure to confirm a diagnosis of gallbladder disease is the oral cholecystogram. An accuracy rate approaching 98 percent has been reported. Usually a gallbladder with no radiographic evidence of calculi is interpreted as normal.

In recent years the reliability of ultrasonic diagnosis in abdominal disease has been publicized widely.[1] After an inauspicious beginning, ultrasonic examination of the gallbladder has earned greater appreciation. It can be used for those patients who had an initial non-visualized oral cholecystogram, those who are jaundiced, or those who are pregnant and can not risk radiographic exposure.[2,3,4] Along with improved technique, the diagnostic accuracy of this non-invasive modality is increasing constantly. In many patients, ultrasonic examination can replace the standard radiographic studies with a high level of confidence.

Diagnosing gallstones can be quick and accurate using cholecystoechography. This study was undertaken to calculate the accuracy of cholecystoechograms, to compare the echo study with the standard radiographic techniques, and to define the echo study's use in the management of gallbladder disease, especially that associated with cholelithiasis.

## Materials and methods

We studied 209 patients who underwent cholecystoechography and whose charts were available. The ultrasound exam was performed with a commerically available B-scanner while the patient was in the supine and upright position. We considered an exam positive when stones were visualized. Other criteria such as thickness of gallbladder wall, or size of gallbladder, were used only as supportive evidence.

*Drs. Comerota and Maier are from Temple University Hospital and Dr. Breckenridge is from Abington Memorial Hospital.*

We considered the standard oral cholecystogram negative when the gallbladder was visualized and no pathology was identified. We considered the x-ray positive in two cases: when calculi were seen; and when hepatic disease was not present and the gallbladder was not visualized after the double dose cholecystogram.

## Results

Of the 209 patients, 80 were echo positive for stones, 107 were negative, and 14 had non-visualized gallbladders. In eight patients the gallbladder was not visualized adequately due to poor technique or to massive obesity.

Of the 80 patients who were echo positive, 50 came to surgery and in 49 the echo diagnosis was confirmed. Of the 107 negative echos, 10 patients were eventually taken to the operating room, and two of these patients were found to have cholelithiasis. Of the 14 patients with non-visualized gallbladders despite technically good studies, five were operated on and were found to have diseased gallbladders.

Our accuracy rate of cholecystoechography was 95 percent. Operative findings were used as the final diagnosis, but figures from the patients with non-visualized and inadequately visualized gallbladders were not used in calculating the accuracy rates. Our overall accuracy was 57 of 60 operated patients having a correct preoperative echo. In three cases the echo proved incorrect.

We had a false positive rate of one in 50 (2 percent) and a false negative rate of two in 10 (20 percent).

The ultrasound positive group was divided into three main categories: ultrasound positive and X-ray positive; ultrasound positive alone; and ultrasound positive and x-ray positive; togram negative. (See Table I.) Those patients who had combined x-ray positive and ultrasound positive studies had a virtual 100 percent diagnostic accuracy. Of the 42 patients with a positive ultrasound as the only diagnostic study, 24 were operated upon and the echo was proved correct in 23. Note that in the third group, two of the four patients who had normal oral cholecystograms but ultrasound exams positive for stones were operated upon, and surgery confirmed both preoperative echo studies.

**TABLE I**
**Ultrasound Positive**

| *Group* | *No.* | *Surgery* | *Surgery Positive* |
|---|---|---|---|
| 1. Echo and x-ray positive | 34 | 24 | 24 |
| a. Oral GB positive | 21 | 16 | 16 |
| b. Oral GB and IVC positive | 2 | 1 | 1 |
| c. IVC positive | 9 | 7 | 7 |
| 2. Echo positive alone | 42 | 24 | 23 |
| 3. Echo positive and oral GB negative | 4 | 2 | 2 |
| Total | 80 | 50 | 49 |

**TABLE II**
**Ultrasound Negative**

| *Group* | *No.* | *Surgery* | *Surgery Positive* |
|---|---|---|---|
| Echo negative and oral GB positive | 12 | 1 | 0 |
| Echo and oral GB negative | 16 | 1 | 0 |
| Echo and IVC negative | 7 | 1 | 0 |
| Echo negative alone | 72 | 7 | 2 |
| Total | 107 | 10 | 2 |

*Figure 1a.* Ultrasound of cross section of abdomen of patient in supine position showing thick debris at most dependent portion of the gallbladder. No true stone formation is observed.

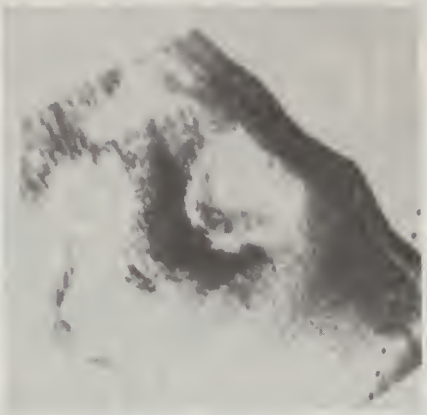

*Figure 1b.* The same patient rotated to the left lateral decubitus position. Note debris from shifting at most dependent portion of the gallbladder.

Table II categorizes our ultrasound negative group. Only two of these patients went to surgery with a suspicion of gallbladder disease, and both had only an echogram as a preoperative study. Stones were found in both instances. Eight other patients underwent abdominal exploration for other reasons and their gallbladders were normal.

Upon operation four of five patients with a non-visualized echo and oral cholecystogram or IVC positive had a diseased gallbladder. One of eight patients with a non-visualized echo alone was operated upon and found to have cholelithiasis. Of seven patients with an inadequately visualized gallbladder on echo, two were operated upon for other reasons and their gallbladders were normal.

## Discussion

Cholecystoechography has been established as a useful diagnostic technique for patients with jaundice, non-visualized gallbladders, or those patients sensitive to cholangiographic agents. It is also valuable in the management of pregnant females and others in whom standard radiographic procedures fail to give the desired information.[2,3,4]

The ultrasonic examination of the gallbladder has not been recommended as the initial or screening procedure by many authors because the oral cholecystogram is reported as the more accurate of the two methods.[2,3] Indeed several authors used the oral cholecystogram as the definitive study in assessing the accuracy of the echogram.[6,7]

The overall accuracy in our series of patients is 95 percent, a figure comparable to Bartrum's reported overall accuracy of 93 percent,[6] and Prian's accuracy of 91 percent.[7] Our report differs from these studies because we used actual surgical findings to determine accuracy whereas the latter authors used surgery or the oral cholecystogram.

We have shown that in instances where the ultrasound and oral cholecystogram do not concur, the ultrasonic exam is more accurate, especially in cases where the ultrasound is positive and the cholecystogram is negative.

Examining the 50 patients with positive ultrasounds who were operated upon, the ultrasound proved correct in 49, a specificity of 98 percent. The sensitivity of the echo study was 80 percent. Again, our results are in keeping with the findings reported in the literature.

In our series three patients had differing oral cholecystogram and echo study results. Two patients had an apparently normal gallbladder on oral cholecystogram, but ultrasound revealed stones. The third patient had what was interpreted as gallbladder disease on oral cholecystogram (double dose non-visualization) but a normal echo. In each of these cases, the ultrasound findings were substantiated at surgery. These findings seem to diminish the reliability of the oral cholecystogram when it differs from the echo.

We reviewed the preoperative studies of the two echo negative patients who were found to have stones at surgery to determine why the operative findings differed from the echogram. Even retrospective analysis of one of these patients' echograms could not reveal the presence of stones; we accept this as true diagnostic error on the basis of technique. The second patient's echo was interpreted preoperatively as a negative study by a physician not trained in evaluating ultrasound; an ultrasonographer eventually interpreted it as obvious stones.

The false negative rate of 20 percent deserves further comment. Ten patients with negative echo studies were operated upon and two were found to have stones. Most patients with negative studies refused surgery. Since surgical findings were used as the ultimate proof of diagnosis, our false negative rate was skewed significantly higher.

An argument against using ultrasound as a routine screening procedure is that a high percentage of gallbladders cannot be visualized.[2] In a small series of patients reported by Tabritsky, et. al, all non-identifiable gallbladders by ultrasound were proven surgically to contain stones.[8]

We feel that further diagnostic accuracy can be achieved by separating the non-visualized group into two subgroups. One subgroup, inadequately

*Figure 2.* Ultrasound obtained from patient with non-visualized oral cholecystogram depicting the presence of sludge layered in the fundus of the gallbladder (patient in upright position).

visualized, seemed to be a poor echo study for technical reasons or obesity. Truly non-visualized gallbladders are those with technically good studies but apparently diseased gallbladders. These include gallbladders that are chronically contracted fibrotic organs or those filled with stones, such that no interface of surfaces necessary for reflection of an echo is available. There were five non-visualized gallbladders operated upon in this series and all were found to be diseased. We maintain that a non-visualized oral cholecystogram followed by a non-visualized echogram is diagnostic evidence of a diseased gallbladder.

These facts and the rapidity in performing an ultrasound exam support our recommendation that the echo be used as an effective and reliable screening study. The ultrasound exam costs more than the routine oral cholecystogram, but if additional contrast material, radiation exposure, trips to the x-ray department, and diagnostic delay, can be avoided, the cost/benefit ratio of ultrasound may be better than that of the standard oral cholecystogram. □

*Figure 3a.* **Normal oral cholecystogram in patient with symptoms suggestive of gallbladder disease.**

*Figure 3b.* **Ultrasound of gallbladder of same patient showing small stones and sludge. Surgery proved ultrasonic diagnosis correct.**

### REFERENCES


1. **Templeton, A. W., Stuber, J. L.:** Abdominal and retroperitoneal ultrasound. *Am. J. Roentgen. Rad. Ther. Nuclear Med., 115:*741, 1971.
2. **Doust, B. D., Makled, N. F.:** Ultrasonic B-mode examination of the gallbladder. *Radiology, 110:*643, 1974.
3. **Goldberg, B. B., Harris, K., Broocher, W.:** Ultrasonic and radiographic cholecystography. *Radiology, 111:*405, 1974.
4. **Hublitz, U. F., Kahn, P. C., Sell, L. A.:** Cholecystosonography: an approach to the non-visualized gallbladder. *Radiology, 103:*645, 1972.
5. **Drian, G. W., Lawrence, W. N., Eule, J., Eiseman, B.:** Clinical indications and accuracy of grey scale ultrasonography in the patient with suspected biliary tract disease. *Am. J. Surg., 134:*705, 1977.
6. **Bartrum, R. J., Crow, H. C., Foote, S. R.:** Ultrasonic and radiographic cholecystography. *N. Engl. J. Med., 296:*538, 1977.
7. **Richardson, R., Norton, L. W., Eule, J., Eiseman, B.:** Accuracy of ultrasound in diagnosing abdominal masses. *Arch. Surg., 110:*933, 1975.
8. **Taylor K., Carpenter, D.A.:** The anatomy and pathology of the porta hepatis demonstrated by grey scale ultrasonography. *J. Clin. Ultrasound, 3:*117, 1975.
9. **Baker, H. L., Hodgson, J. R.:** Further studies on the accuracy of oral cholecystography. *Radiology, 74:*239, 1960.
10. **Carlsen, E. N.:** Liver, gallbladder and spleen. *Radiologic Clinics of North America, 13*(3): 1975.
11. **Janower, M. L.:** Ultrasound examination of the gallbladder. (Editorial). *JAMA,* 1237. No. 5.
12. **Mujahed, Z., Evans, J. A., Whalen, J. P.:** The non-opacified gallbladder on cholecystography. *Radiology, 112:*1, 1974.
13. **Tabritsky, J., Lindstrom, R. R., Herman, M. W., Castagna, J., Sarti, D.:** Value of gallbladder B-scan ultrasonography. *Gastroenterology, 68:*1246, 1975.



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# Proceedings
# 130th Annual Meeting of the House of Delegates
# Camp Hill, November 1-3, 1979

*Secretary's Note: Copies of all reports, annotated reference committee reports, addresses, and resolutions in their entirety are available on request.*

## Opening Session of the House
## November 1, 1979

D. Ernest Witt, M.D., Speaker of the House, called the opening session of the House of Delegates to order at 10:10 a.m., Thursday, November 1, 1979, in the Grand Ballroom of the Penn Harris Motor Inn, Camp Hill.

**Committee on Credentials**

John P. Whiteley, M.D., York County, Chairman of the Committee on Credentials, presented the following report:

"Mr. Speaker, there is a quorum of 184 delegates registered and in attendance today."

**Invocation**

Wilbur E. Flannery, M.D., Lawrence County, offered the invocation.

**Committee on Rules**

William J. West, M.D., Cumberland County, Chairman of the Committee on Rules, presented the following written report:

"Mr. Speaker and members of the House of Delegates: the Reference Committee on Rules met and unanimously approved the adoption of the Standing Rules of the House of Delegates of the Pennsylvania Medical Society as published in the 1979 Official Reports Book.

"Mr. Speaker, I recommend that the Standing Rules of the House of Delegates be adopted as presented."

The House approved the report of the Committee on Rules.

**Approval of Proceedings**

The Proceedings of the 129th Annual Meeting of the Society, held in Lancaster, October 30-November 1, 1978, and found on pages 48-69 in the January 1979 issue of PENNSYLVANIA MEDICINE, were approved.

**Necrology Report**

The House stood in tribute following the Necrology Report presented by David J. Keck, M.D., Chairman of the Board of Trustees:

"At this time, it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania Medical Society.

"From September 1, 1978 to August 31, 1979, we have lost by death 181 members: 8 not over 50 years of age; 83 between 51 and 70; 86 between 71 and 90; and 4 in the group aged 91 and over. Of these 181 members, 93 were Associates, all of whom were 70 years of age or over. The Necrology Report at the last Annual Session reported the loss of 180 members.

"May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

**Speaker's Announcements**

Dr. Witt announced that delegates should be aware of Resolution 72-6 prohibiting smoking in the House of Delegates or reference committee hearings.

Dr. Witt next announced that Dr. Jessie Weigle of the Pennsylvania Chapter of the American College of Emergency Physicians was providing emergency medical coverage on a 24-hour basis during the annual meeting.

**Distinguished Guests**

The following distinguished guests were presented to the House: Dr. Stephen K. Padussis, President Elect, Medical and Chirurgical Faculty of Maryland; and Bricy K. Wendell, CMA-A, President, Pennsylvania Society, American Association of Medical Assistants.

**Report of AMA Delegation**

As required by the resolve portion of Resolution 71-1: AMA Delegation Report and Plans, the House received a brief report from John B. Lovette, M.D., Johnstown, Chairman of the Pennsylvania Delegation:

"Mr. Speaker, members of the House of Delegates:

"In your Official Reports Book under items referred to Reference Committee G, you will see a complete report of the activities of the Pennsylvania Delegation to the AMA. I would like, at this time, to add my personal comments about the accomplishments of the 22-member contingent who speaks for all of you at the national level.

"Pennsylvania was well represented at the annual and clinical meetings of the AMA which were both held in Chicago. With the official delegation, student, resident, and specialty representatives, we had nearly 40 people contributing to our discussions. This year we implemented a new system that allows for participation by every member of the Delegation. Delegates and alternates alike are assigned to reference committees, and they must report to the caucus daily on the actions of the reference committee. Through careful scheduling we see to it that the person who attended the reference committee hearing is present when the committee's report is presented to the House of Delegates.

"Pennsylvania's representation at the national level continues to increase. You will recall that last year, we were successful in George Rowland's campaign for the AMA Board. This year Bill Rial was re-elected as Speaker of the House. We believe two years from now he will be president of the AMA. Betty Cottle was elected to the AMA's Council on Constitution and Bylaws. At the annual meeting in Chicago, Bill Kellow, of Jefferson, was elected to a three-year term on the AMA Council on Medical Education. Our success rate can be attributed to both the fine candidates we have and to our well organized political campaigns.

"One of the main issues at this year's meeting was the pro-

posed revisions to the AMA Code of Ethics. This issue will again be discussed when the Ad Hoc Committee to Consider Changes renders its final report to the House next July. In the meantime, the AMA's Ad Hoc Committee has asked state societies to get input from their membership and to report back to the Ad Hoc Committee. You will have an opportunity today to offer your comments when this matter is considered by Reference Committee A.

"This solicitation of members' comments on the ethics issue is just one example of how the AMA speaks for all physicians. Through the Pennsylvania Delegation, every PMS member has the opportunity to have a hand in the direction of organized medicine. I hope that each one of you will provide your Delegation with input. They exist for your purposes. They are a hard working, dedicated group, and I think you can see by their past accomplishments, highly effective as well.

I also urge everyone of you to promote AMA membership whenever possible. Encourage your colleagues to join the AMA and to become active at all levels of organized medicine. Only through a united front can we guide the direction of national issues which affect each one of us."

**Pennsylvania Delegation Meeting**

It was announced that the Pennsylvania Delegation to the AMA would hold a business meeting Thursday evening, November 1 at 7p.m. in Keystone B, with dinner following at 8p.m. in Keystone E.

**Address of President**

John B. Lovette, M.D., Cambria County, President, presented a report on many areas in which the Society has been active during his tenure as president. Dr. Lovette's report was referred to Reference Committee G; however, specific recommendations were referred to appropriate reference committees. Specific recommendations include: the question of chiropractic encroachment into the practice of medicine be referred to the Council on Legislation (referred to Reference Committee D); physicians in Pennsylvania declare a one-year moratorium on fee increases (referred to Reference Committee C); and membership intake procedures be simplified (referred to Reference Committee F).

**Report, Pennsylvania Medical Cooperative**

Kenneth L. Cooper, M.D., Lycoming County, President of the Pennsylvania Medical Cooperative, presented a status report on the Co-op. This report was referred to Reference Committee F.

**Report, Pennsylvania Medical Political Action Committee**

J. Preston Hoyle, M.D., Union County, Chairman of the PaMPAC Board of Directors, presented an informational report.

**Address of President Elect**

Matthew Marshall, Jr., MD, Allegheny County, President Elect, presented a report on his plans for the upcoming year. Dr. Marshall's address was referred to Reference Committee G; however, specific recommendations were referred to appropriate reference committees. Specific recommendations include: next year be the year of the health care consumer (referred to Reference Committee C); the House request that the Board of Trustees have its new planning committee adopt, as a top priority, an investigation of the growing burden of paperwork created by various programs, both those supported by PMS and those created by outside sources, and to make recommendations to the 1980 House of Delegates (referred to Reference Committee C); the House endorse a policy of assisting medical staffs to participate on the hospital board of directors and board committees (referred to Reference Committee C); that the PMS program of assisting medical staffs be expanded to include training in this area, and that this instruction include skills in the arts of negotiation (referred to Reference Committee C); the House commend the AMA for its actions in the field of FTC rulings (referred to Reference Committee G); that we continue our drive to recruit AMA members and the House reconsider unified membership (referred to Reference Committee F); and we take advantage of the American Osteopathic Association change of policy to increase the number of osteopathic physicians in PMS (referred to Reference Committee F).

**FTC Presentation**

Barbara Mathers, Esq., a partner in the law firm of Pepper, Hamilton & Scheetz, made the presentation.

**Special Report of Building Project**

David J. Keck, M.D., Chairman of the Board of Trustees, presented the report.

**Introductions**

Donald E. Harrop, M.D., Chester County, Vice Speaker of the House of Delegates, introduced Society officers, members of the Judicial Council and of the Board of Trustees, and PMS past presidents.

**Pennsylvania Medical Care Foundation Announcement**

The following announcement was made by the Vice Speaker with regard to the Pennsylvania Medical Care Foundation:

"As you know, according to the bylaws of the Medical Care Foundation, members of the PMS House of Delegates are also the administrative members of the Pennsylvania Medical Care Foundation. The 1979 annual report of the Board of Directors of the Pennsylvania Medical Care Foundation has been previously mailed to you with your *Official Reports Book* and is referred to Reference Committee C. The annual meeting of the Foundation will be held during tomorrow's session following the report of Reference Committee C."

**Special Budget Report**

Kenneth L. Cooper, M.D., Lycoming County, Chairman of the Finance Committee, presented the special report.

**Remarks, President of Auxiliary**

Mrs. Howard F. Conn, President, Pennsylvania Medical Society Auxiliary, addressed the House and reported on the activities of the Auxiliary. Her remarks were referred to Reference Committee F.

**Remarks, President of AMA Auxiliary**

Mrs. Ben Johnson, Jr., President of the American Medical Association Auxiliary, addressed the House. Her remarks were received for information.

**Report, Pennsylvania Medical Society Liability Insurance Company**

David S. Masland, M.D., Cumberland County, Chairman of the Board of PMSLIC, presented a report to the House. This report was referred to Reference Committee E.

**Official Reports Book**

The *Official Reports Book,* containing the 1979 annual reports and resolutions 79-1 through 79-28, was accepted as business of the House.

Late Resolutions—Resolutions 79-29 through 79-44—were received subsequent to the mailing of the *Official Reports Book* and required a two-thirds vote to become business of the House. The House accepted these resolutions.

Resolutions 79-45 through 79-48 were received after the House convened and required a three-quarters vote to become business of the House. The House accepted these resolutions.

Please refer to the index of these Proceedings for the subject, author, introducer, and referral of all resolutions.

**Reference Committees**

Reference committees for the 1979 annual meeting of the House of Delegates are listed below:

**Reference Committee A:** *John Y. Templeton, III (Philadelphia), Chairman; *Norman A. Goldstein (Chester); *Wayne W. Helmick (Beaver); *Robert M. Jaeger (Lehigh); *Ralph J. Stalter (Allegheny); and Frank J. Tornetta (Montgomery), alternate.

**Reference Committee B:** *Robert M. Pilewski (Venango),

Chairman; *Winfield S. Gibbs (Northumberland); *Arthur J. Patterson (Greene); *Nancy M. Swenson (Allegheny); *Doris G. Bartuska (Philadelphia); and Dante Landucci (AMSA-University of Pittsburgh), alternate.

**Reference Committee C:** *Robert W. Ford (Allegheny), Chairman; *Joseph F. Alcaro (Adams); *Joseph B. Blood, Jr. (Bradford); *Harmon J. Machanic (Lycoming); *Irvin G. Shaffer (Berks); and Rita F. Redberg (AMSA-Penn), alternate.

**Reference Committee D:** *Frederick G. Brown (Montour), Chairman; *James R. Hamsher (Crawford); *Leopold S. Loewenberg (OB/GYN); *Jonathan E. Rhoads, Jr. (Philadelphia); *Jane A. M. Strickler (Centre); and William R. Dewar (Wayne-Pike), alternate.

**Reference Committee E:** *Robert E. Gregory (Allegheny), Chairman; *J. Preston Hoyle (Union); *David L. Miller (Clarion); *Donald E. Parlee (Bucks); *R. Edward Steele (Dauphin); and Frans Vossenberg (AMSA-Jefferson), alternate.

**Reference Committee F:** *Jon S. Adler (Washington), Chairman; *Paul A. Cox (Ophthalmology); *Charles Heisterkamp, III (Lancaster); *William D. Lamberton (Erie); *Brooke Roberts (Philadelphia); and John G. Hallisey (Beaver), alternate.

**Reference Committee G:** *Charles K. Zug, III (Northampton), Chairman; *Alan L. Dorian (Montgomery); *J. Scott Homer, Jr. (PAFP); *J. Campbell Martin (Columbia); *John T. McGeehan (Elk-Cameron); and Jaan Siderov (AMSA-Hershey), alternate.

**Rules:** *William J. West (Cumberland), Chairman; *David L. Kerstetter (Bedford); *William C. Long, Jr. (Clinton); *Robert N. Moyers (Crawford); and *R. Robert Tyson (Philadelphia).

**Credentials:** John P. Whiteley (York), Chairman; R. William Alexander (Berks); John A. Burkholder (Allegheny); Gilbert M. Hoffman (Northampton); and Donald G. Crawford (Dauphin).

**Tellers:** Robert B. Stuart (Erie), Chairman; Samuel Baer (Philadelphia); Carmela F. deRivas (Montgomery); William W. Greff (Cambria); and Wallace O. Lecher (Delaware).

**Indicates those members who signed the report.*

**Additional Reports**

The following reports were received subsequent to the mailing of the *Official Reports Book*. They are: Report B of the Judicial Council; revised Report E of the Council on Education and Science; Report B of the Council on Legislation; Report of the Pennsylvania Medical Cooperative; Report H of the Board of Trustees; Report of the Educational and Scientific Trust; and Report of Pennsylvania Blue Shield. Please refer to the index of these Proceedings for the reference committee referral.

**Recess**

The House of Delegates was recessed at 12:50 p.m. until 1:00 p.m. Friday.

## Second Session of the House
## November 2, 1979

The second session of the House of Delegates was called to order at 1:15 p.m. in the Grand Ballroom of the Penn Harris Motor Inn, Camp Hill.

**Committee on Credentials**

John P. Whiteley, MD, York County, Chairman of the Committee on Credentials, presented the following report:

"Mr. Speaker, there is a quorum of 221 delegates registered and in attendance today.

"County medical societies not represented are: Carbon, Clearfield, Huntingdon, Jefferson, McKean, Perry, Potter, Susquehanna, Wayne-Pike, and Wyoming.

"Specialty societies not represented are: Clinical Pathology, Pediatrics, and Urology."

**Speaker's Announcement**

D. Ernest Witt, MD, the Speaker, noted that Article VI, Section 3 of the Constitution states that: "If any component society is without any duly accredited voting member of the House of Delegates at any session thereof, then the Active, Senior Active, Associate, Intern or Resident member or members registered in attendance in that component society may select himself or one delegate from their number, as the case may be, who shall be the representative of that component society and shall serve in the place of an accredited delegate."

**Distinguished Guests**

The following distinguished guests were presented to the House at various times during the session: L. Walter Fix, MD, President-Elect, West Virginia State Medical Association; Alan J. Vogenberg, RPh, President, Pennsylvania Pharmaceutical Association; Robert B. Flinn, MD, President-Elect, Medical Society of Delaware; Alfred A. Alessi, MD, President, Medical Society of New Jersey; and G. Rehmi Denton, MD, President, Medical Society of the State of New York.

Dr. Witt then introduced William Y. Rial, MD, Speaker of the AMA House of Delegates, and George A. Rowland, MD, AMA Trustee. Both delivered brief remarks to the House.

### Reference Committee A
### Presented by: John Y. Templeton, III, MD

Mr. Speaker, members of the House of Delegates:

REPORT OF THE AD HOC COMMITTEE ON THE PRINCIPLES OF MEDICAL ETHICS OF THE AMA HOUSE OF DELEGATES

The report of the Ad Hoc Committee on the Principles of Medical Ethics of the AMA House of Delegates was referred to the component societies of the federation for consideration and recommendation. Your reference committee heard spirited debate, pro and con, on the report of the AMA Ad Hoc Committee, and Report B of the PMS Judicial Council. The weight of the discussion favored the proposed revision of the Principles of Medical Ethics. Your reference committee unanimously agreed that the wording of the proposed version of the Principles of Medical Ethics retains the essence of the existing Principles of Medical Ethics and preserves the rights and responsibilities of the individual physician.

*Mr. Speaker, your reference committee recommends approval of the proposed version of the AMA Principles of Medical Ethics.*

Amendments offered from the floor of the House were rejected. The House approved the proposed version of the AMA Principles of Medical Ethics.

REPORT B, JUDICIAL COUNCIL

Your reference committee found Report B of the Judicial Council extremely helpful in its deliberation of the subject at hand and commends the Council for its thoughtful contribution.

*Mr. Speaker, your reference committee recommends that Report B of the Judicial Council be filed.*

The House approved the filing of Report B.

REPORT A, COMMITTEE ON CONSTITUTION AND BYLAWS

Your reference committee considered Report A of the Committee on Constitution and Bylaws. Because four separate topics are considered in this report, your reference committee separated them.

SUBJECT ONE. Judicial Council Eligibility Qualifications to Include Alternate Delegates Who Serve as Delegates in the House. During the 1978 Reference Committee A hearing, testimony was heard to allow alternate delegates to be eligible for Judicial Council if they are seated as delegates. The House of Delegates approved the reference committee's recommendation and referred the matter to the Standing Committee on Constitution and Bylaws to prepare appropriate language.

*Mr. Speaker, your reference committee recommends the adoption of language as presented in Subject One of the Of-*

*ficial Call which expands Section 6 of Article IX to include alternate delegates as eligible for the Judicial Council if personally registered and in attendance at least at one session of the House of Delegates per year of each of his five elected years.*

SUBJECT TWO. Terms of Office - Board of Trustees and Councilors. In 1978, the House of Delegates instructed the Standing Committee to prepare language which would permit a Trustee to serve three consecutive terms. Additionally, when the House approved the reduction of the term a trustee may serve, it was necessary to change the length of time constituting a term when a vacancy is filled. The Standing Committee on Constitution and Bylaws prepared language to accommodate the needed changes.

*Mr. Speaker, your reference committee recommends the adoption of language as presented in Subject Two of the Official Call which changes the number of consecutive terms for trustees and councilors and the length of time considered to be a term when a vacancy is filled.*

The House adopted the Constitutional change in Section 2 of Article VIII.

SUBJECT THREE. Establishing as a Standing Committee of the Society, the Advisory Committee on Professionalism. There was much interested discussion on this proposal. Your reference committee heard a detailed report by the Secretary regarding the need and function of a clearinghouse mechanism, separate from the Judicial Council.

*Mr. Speaker, your reference committee recommends the adoption of the bylaws language as presented in Subject Three of the Official Call which provides for a Standing Committee of this Society to be named the Advisory Committee on Professionalism and which describes the composition, duties, and responsibilities of this Committee, with the following editorial changes: that "Secretary's" be deleted from the title of the Advisory Committee; and that under "Duties" item iii read "to refer to appropriate licensing body" instead of the "State Board of Medical Education and Licensure."*

The House adopted the Bylaws language, new paragraph f, Section 2 of Chapter XIV.

PART TWO OF REPORT A OF THE COMMITTEE ON CONSTITUTION AND BYLAWS. The Standing Committee on Constitution and Bylaws was charged with the revision of the PMS Constitution and Bylaws at the 1978 House of Delegates meeting. This revision has been prepared but has not been studied exhaustively by the entire Standing Committee.

*Mr. Speaker, your reference committee recommends this House of Delegates approve the continuation of the work on the revision of the PMS Constitution and Bylaws with a progress report or a proposed revision to be presented to the 1980 House of Delegates.*

The House approved the recommendation of the Standing Committee on Constitution and Bylaws, Part Two of Report A.

REPORT B, SECRETARY

The subject of Report B of the Secretary concerned the need for the Advisory Committee on Professionalism. The debate on this report was heard under the previous Index item, which the House has just considered.

*Mr. Speaker, your reference committee recommends that Report B of the Secretary be filed, with commendation to the Secretary and his Ad Hoc Committee on Discipline.*

The House approved the filing of Report B of the Secretary, with commendation to the Secretary and his Ad Hoc Committee on Discipline.

RESOLUTION 79-28, ELIMINATION OF COMPULSORY MEMBERSHIP REQUIREMENT FOR OSTEOPATHS

*RESOLVED, That the Pennsylvania Medical Society change the Bylaws to permit an osteopathic physician to become a member of the county medical society where he practices without becoming a member of the Pennsylvania Medical Society, provided there is no local or county osteopathic society and the osteopathic physician is a member of the Pennsylvania Osteopathic Medical Association.*

Your reference committee heard limited debate on Resolution 79-28. Sole support for this resolution came from the sponsoring county; the main discussion was opposed to the adoption of this resolution.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-28.*

The House rejected Resolution 79-28.

RESOLUTION 79-35, ELECTION TO JUDICIAL COUNCIL

*RESOLVED, That the Constitution be amended so that the Board of Trustees nominates one individual for each vacancy on the Judicial Council and not three individuals; and be it further*

*RESOLVED, That the Standing Committee on Constitution and Bylaws prepare the appropriate language for the amendment to be presented for adoption at the 1980 House of Delegates Annual Meeting.*

Aside from the support of the sponsor, all discussion was in opposition to this resolution to reduce to one the nominees for a Judicial Council position.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-35.*

The House rejected Resolution 79-35.

## Reference Committee B
## Presented by: Robert M. Pilewski, MD

Mr. Speaker, members of the House of Delegates:

The following items have been grouped together in a waiver of debate list; in each case, little or no testimony was heard and the committee feels the items are of a non-controversial nature.

Report A, Council on Education and Science, Administration and Liaison, (File)

Report D, Council on Education and Science, Continuing Education Studies (File)

*Mr. Speaker, your reference committee recommends that the above items be filed.*

The House approved filing the waiver of debate items.

REPORT B, COUNCIL ON EDUCATION AND SCIENCE, MEDICAL EDUCATION AND MANPOWER

Your reference committee believes the only significant item needing action in Report B of the Council is the suggested policy statement subject: Physician Relationships to Non-Physician Health Care Practitioners.

Support of this policy statement will benefit the Society in future relationships with non-physician health care practitioners who are doing limited medical practice by clarifying the three part relationship that exists in some aspects of health care between the physician, the non-physician health care practitioner, and the patient.

*Mr. Speaker, your reference committee recommends the adoption of the suggested policy statement "Physician Relationships to Non-Physician Health Care Practitioners."*

The House adopted the policy statement, "Physician Relationships to Non-Physician Health Care Practitioners."

RESOLUTION 79-27, Use of Non-Physician Health Care Providers in Accredited Continuing Medical Education Programs

*RESOLVED, That all associations, facilities, and programs authorized to approve programs of continuing medical education be made aware of the differing relationships between the physician and the non-physician health care provider in the total delivery of health care; and be it further*

*RESOLVED, That those differences in function be considered in the planning and implementation of CME activities; and be it further*

*RESOLVED, That, when a course offering is being planned which involves non-physician health care providers who relate to a physician specialty, representatives of that specialty be included in the planning process to insure that the proper relationship between the physician and non-physician is conveyed; and be it further*

*RESOLVED, That this principle be adopted by the Pennsylvania Medical Society as a policy to be followed in approving CME activities; and be it further*

*RESOLVED, That this information be forwarded to all state specialty organizations, CME accrediting organizations and institutions, and to the American Medical Association as an expression of interest and concern and for possible adoption as policy.*

Your reference committee supports the concept of this resolution and heard no adverse comment from those attending the reference committee hearing. We believe by amending the resolves we can clarify the intent of the resolution. Your reference committee therefore recommends the following substitute resolve:

*RESOLVED, That when a CME course offering is being planned which involves non-physician health care providers who relate to a physician specialty, physician representatives of that specialty be included in the planning process to insure that the proper relationship between the physician and non-physician is conveyed; and be it further*

*RESOLVED, That this information be forwarded to all state specialty organizations, CME accrediting organizations and institutions, and to the American Medical Association as an expression of interest and for possible adoption as policy.*

*Mr. Speaker, your reference committee recommends adoption of the substitute resolution.*

The House adopted the substitute resolution.

RESOLUTION 79-9, "1985 PROPOSAL" NURSING EDUCATION

*RESOLVED, That the Pennsylvania Medical Society strongly oppose the entire concept of the "1985 Proposal" and support the importance of accessible education for all nurses.*

Your reference committee heard considerable support for this resolution and agrees that the issue of nursing education, the 1985 proposal, presents great concern to the health care industry because of the possible curtailment of nurses. The support of this resolution reaffirms the Society's present policy that multiple avenues of training be available to those entering the nursing profession.

*Mr. Speaker, your reference committee recommends the adoption of Resolution 79-9.*

The House adopted Resolution 79-9.

REPORT C, COUNCIL ON EDUCATION AND SCIENCE, SCIENTIFIC ACTIVITIES

Report C of the Council addresses an issue that has been before this House of Delegates on a number of occasions. In each case, there was never a definitive statement presented for consideration that would clearly define the society's concern regarding multiphasic screening. Such a statement now has been prepared by the Council.

*Mr. Speaker, your reference committee recommends adoption of the suggested policy statement "Multiphasic Screening."*

The House adopted the policy statement, "Multiphasic Screening."

RESOLUTION 79-14, PMS Oppose Performance of Medical Procedures Without Specific Advance Arrangements with a Properly Qualified Medical Practitioner

*RESOLVED, That the Pennsylvania Medical Society oppose the performance of medical procedures unless specific advance arrangements are made for receipt of data, interpretation, follow-up, and record retention by a properly qualified medical practitioner. Large amounts of this unrequested data currently are being generated by various agencies and commercial groups.*

This resolution also speaks to the problem of multiphasic screening. Your reference committee believes that the intent can be clarified by the deletion of the last sentence. The resolve should now read:

*RESOLVED, That the Pennsylvania Medical Society oppose the performance of medical procedures unless specific advance arrangements are made for receipt of data, interpretation, follow up, and record retention by a properly qualified medical practitioner.*

*Mr. Speaker, your reference committee recommends the adoption of amended Resolution 79-14.*

The amendment offered from the floor of the House was rejected. The House adopted amended Resolution 79-14.

RESOLUTION 79-3, SAFETY STANDARDS FOR NUCLEAR POWER FACILITIES

*RESOLVED, That the Pennsylvania Medical Society insists on clear assurances from the Nuclear Regulatory Commission and other local and state government authorities that the nuclear power and waste facilities within a one hundred mile radius of Lancaster County satisfy the highest possible standards of safety and that existing deficiencies be addressed immediately.*

Your reference committee and all members of the Society are sympathetic to the concerns expressed by the Lancaster County Medical Society regarding safety aspects and standards of nuclear power. We believe that concern should be reflective of all portions of our state since nuclear generating plants are located throughout the Commonwealth. Therefore we amend Resolution 79-3 as follows:

*RESOLVED, That the Pennsylvania Medical Society insist on clear assurances from local, state, and federal governmental authorities that nuclear power and waste facilities satisfy the highest possible standards of safety and that existing deficits be corrected immediately.*

*Mr. Speaker, your reference committee recommends the adoption of Resolution 79-3 as amended.*

The House approved amendments from the floor of the House to delete "local, state, and federal" from the resolution, and to commend the Governor and congratulate the former Secretary of Health for the manner in which the Three Mile Island crisis was handled.

RESOLUTION 79-32, HEALTH PASSPORT

*RESOLVED, That the Pennsylvania Medical Society urge all physicians and other health care professionals who treat children to consider using the proposed child Health Passport in their practice.*

Your reference committee supports the activities of the Pennsylvania Committee for the International Year of the Child.

*Mr. Speaker, your reference committee recommends the adoption of Resolution 79-32.*

The House adopted Resolution 79-32.

REPORT E, COUNCIL ON EDUCATION AND SCIENCE, ABORTION, REVISED REPORT

As in previous years, the discussion on abortion was sincere, eloquent, and lengthy. Much of the testimony was directed at the

basic question as to whether abortions ought to be performed. However, this was not the fundamental question before your reference committee. The first Society policy adopted in 1967 and reaffirmed in 1976 is for limited abortions under specific conditions. It is a belief of your reference committee that Report E of the Council does not change the basic philosophy that has been reaffirmed by this House on numerous occasions. It does succeed in its original intent to review and re-evaluate our policy in regard to clinical accuracy and administrative practicality. The House should be aware that the changes brought forth in the new suggested policy include the removal of the words gravely and grave, and the elimination of hospital committees composed of physicians who were to examine patients and concur in writing that an abortion was necessary. Additions were made to include clinical outpatient facilities, a statement regarding educational efforts to inform the patient of consequences in relation to human sexuality and contraception, and the recognition that abortions should be performed in hospitals or clinics that are inspected and accredited by professional associations and appropriate state agencies. And finally, a statement that defines informed consent.

Your reference committee believes that the suggested policy statement on abortion as recommended by the Council does establish a position relevant to current medical practice and does not change our basic philosophy.

*Mr. Speaker, your reference committee recommends the adoption of the suggested policy statement, "Abortion."*

The House tabled the suggested policy statement, "Abortion."

RESOLUTION 79-2, REFERENDUM FOR PMS POLICY ON ABORTION

*RESOLVED, That the PMS policy on abortion be referred to the entire membership for approval or rejection in whole or in part; and be it further*

*RESOLVED, That this referendum be completed by March 1980 so that the results may be subsequently tabulated and analyzed by an appropriate body of this Society, communicated to the PMS membership, and reported to the 1980 House of Delegates with recommendations which represent the apparent conclusions of the referendum.*

Testimony before your reference committee generally supports a referendum on a current PMS policy regarding abortion. There are a number of difficulties in undertaking such an activity, including specificity of the question being asked, adequate response, and reliable interpretation. However, your reference committee does believe that there is merit in surveying the membership as to their opinion on whether or not they would agree or disagree with the current position of the Society on abortion. Such a survey could be used to inform the House of Delegates of the membership's feeling and would be a significant aid in any future deliberations by this House in determining a Society policy.

Your reference committee recommends a substitute resolution.

*RESOLVED, That the PMS policy on abortion be sent to the entire membership through a survey to solicit their opinion on whether they approve or disapprove of the present policy position. This survey should be completed by March 1980 so that results may be analyzed by the Board of Trustees, communicated to the membership and reported to the 1980 House of Delegates.*

*Mr. Speaker, your reference committee recommends the adoption of the substitute Resolution 79-2.*

The House approved the amendment to Resolution 79-2 from the floor of the House, instructing that the survey ask the following two questions: Whether or not the respondent approves of the present position of PMS; and whether or not the respondent favors abortion on demand when concurred with in the opinion of the patient's physician. The House adopted the substitute resolution as it was amended from the floor.

It was moved and seconded from the floor of the House that the survey on abortion be sent in the next available all-member mailing. The House approved the motion.

RESOLUTION 79-13, JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION RECONSIDER ITS PREVIOUS ABORTION INTERPRETATION

*RESOLVED, That the Pennsylvania Medical Society request the Judicial Council of the American Medical Association to reconsider its previous action and report to the next annual meeting of the PMS House of Delegates.*

We believe that the intent of this resolution is worthy of a communication to the AMA Judicial Council. We note in all matters of medical procedures the AMA Judicial Council becomes involved whenever there are alleged violations of the Principles of Medical Ethics as established by the House of Delegates. Since the AMA House is on record with a statement on abortion, we believe it would be worthwhile to ask the AMA Judicial Council to provide a current opinion on that position. We therefore recommend the following substitute resolution:

*RESOLVED, That the Pennsylvania Medical Society request the Judicial Council of the American Medical Association to render an opinion on the current position on abortion of the AMA House of Delegates.*

*Mr. Speaker, your reference committee recommends the adoption of the substitute Resolution 79-13.*

The House tabled Resolution 79-13.

RESOLUTION 79-36, ABORTION

*RESOLVED, That the Pennsylvania Medical Society seek a Human Life Amendment to the Constitution of the United States in order to re-establish legal protection of unborn children by law; and be it further*

*RESOLVED, That the Pennsylvania Medical Society membership have a duty to make these facts known; and be it further*

*RESOLVED, That the Pennsylvania Medical Society propose and work for an amendment of the AMA abortion resolutions of 1970 in order to reaffirm the existence of human life before birth, to establish the physician's ethical responsibility for the life and health of both mother and child during pregnancy, and to confirm that abortion is NOT like any other medical procedure, but that it is unique among all medical procedures because it ends the life of one of two patients involved, who BOTH share the same natural right to life.*

Although a number of members spoke in regard to this resolution, your reference committee believes that it is an ambiguous statement and that its intent is not clearly delineated in the resolves. From our analysis, we believe parts of the resolves are inconsistent with the existing policy of the Society on abortion.

*Mr. Speaker, your reference committee recommends the rejection of Resolution 79-36.*

The House tabled Resolution 79-36.

COUNCIL WORK PLAN

The work plan of the Council has been reviewed by your reference committee. We wish to commend the Council for its orderly and concise approach to the problems that face the Society. We believe that the work plan reflects the intent of this House of Delegates.

Your reference committee expresses its appreciation to all members who spoke at the hearing for their sincere interest and help.

## Nominations and Elections

Nominations and elections were held Friday afternoon, November 2, 1979. Voting for those offices contested was held Saturday morning, November 3. The following are the new officers for 1979-80:

**President:** Matthew Marshall, Jr., M.D. (Allegheny) was installed as President.
**President-Elect:** Leroy A. Gehris, M.D. (Berks) acceded to the office of President Elect.
**Vice President:** Raymond C. Grandon, M.D. (Dauphin).
**Secretary:** G. Winfield Yarnall, M.D. (Dauphin).
**Speaker:** D. Ernest Witt, M.D. (Columbia).
**Vice Speaker:** Donald E. Harrop, M.D. (Chester).

The following Trustees and Councilors were elected:
**First District:** Robert S. Pressman, M.D. (Philadelphia).
**Fifth District:** John J. Danyo, M.D. (York).
**Sixth District:** Joseph M. Stowell, M.D. (Blair).

The House approved the verbal expression of appreciation to Dr. Donald R. Cooper for his service as First District Trustee.

Two members were elected to serve on the Committee to Nominate Delegates and Alternates to the AMA. They are: John G. Hallisey, M.D. (Beaver) and David P. Morrison, Jr., M.D. (Bucks). Both were elected to serve full three-year terms on the Committee.

William A. Limberger, MD (Chester) and Cyrus B. Slease, MD (Armstrong) were elected to serve on the PMS Judicial Council.

The following District Censors were elected for one-year terms: Adams, W. North Sterrett; Allegheny, William D. Stewart; Berks, Brian A. Wummer; Blair, John W. Stoker; Bradford, Arthur B. King; Bucks, Stanley F. Peters; Butler, Robert C. McCorry; Cambria, Warren F. White; Centre, H. Thompson Dale; Chester, John B. Coates, Jr.; Clarion, Charles C. Houston; Clinton, George J. Treires; Columbia, Philip M. Irey, Jr.; Crawford, David D. Kirkpatrick, Jr.; Cumberland, Hans S. Roe; Dauphin, Robert B. Edmiston; Delaware, Furman T. Kepler; Elk-Cameron, Robert J. Dickinson; Erie, Robert L. Loeb; Fayette, Veronica Binns; Franklin, Albert W. Freeman; Jefferson, Nicholas F. Lorenzo; Lebanon, George C. Potash; Lehigh, William F. Boucher; Luzerne, Robert Kerr; Lycoming, Franklin G. Wade; McKean, Bruno P. Sicher; Mercer, Francis L. Lally; Mifflin-Juniata, Stephen I. Dodd; Montgomery, Rudolph K. Glocker; Montour, William O. Curry, Jr.; Northampton, Walter J. Filipek; Northumberland, Nicholas Spock; Perry, Frank A. Belmont; Philadelphia, Charles Thompson; Potter, Edward F. Jordan; Somerset, Alexander Solosko; Susquehanna, Paul B. Kerr; Tioga, William P. Reich; Union, John H. Persing; Venango, Harry Kanhofer; Warren, Harold J. Reinhard; Wayne-Pike, Donald W. Henderson; Wyoming, John S. Rinehimer; York, Donald R. Gross.

*(Secretary's note: The Board of Trustees may appoint district censors to fill vacancies.)*

**Report of the Committee to Nominate Delegates and Alternates to the AMA**—The Speaker announced the elections for delegates and alternates to the American Medical Association. The nominations of the Committee to Nominate Delegates and Alternates to the American Medical Association were published on pages 12 and 13 of the *Official Reports Book*. Elected to two-year terms beginning January 1, 1980, and expiring December 31, 1981 were: Henry H. Fetterman, MD (Lehigh); John B. Lovette, MD (Cambria) Matthew Marshall, Jr., MD (Allegheny); Robert N. Moyers, MD (Crawford); and R. Robert Tyson (Philadelphia).

Five alternates were elected for two-year terms beginning January 1, 1980 and expiring December 31, 1981: Robert J. Carroll, MD (Allegheny); George Ross Fisher, III, MD (Philadelphia); Wayne W. Helmick, MD, (Beaver); David J. Keck, MD (Erie); and Donald E. Parlee, MD (Bucks).

Following the nominations and elections, a motion was made from the floor of the House to reconsider the previous action taken by the House to table the recommendation of Reference Committee B to adopt the suggested policy statement, "Abortion," as contained in Report E of the Council on Education and Science. This motion was seconded. The House rejected the recommendation.

## Reference Committee G
## Presented by: Charles K. Zug, III, MD

Mr. Speaker, members of the House of Delegates:

The following items have been grouped together in a waiver of debate list; in each case, little or no testimony was heard and the committee feels the items are of a non-controversial nature.

Report A, Secretary (File)
Report A, Treasurer (File)
Report A, Accountant (File)
Report A, Board of Trustees and Councilors (File)
Individual Reports of Trustees and Councilors (File)
Report A, Pennsylvania Delegation to the AMA (File)
Annual Report of the Educational and Scientific Trust (File)

*Mr. Speaker, your reference committee recommends that the above items be filed.*

The House approved filing the waiver of debate items.

REPORT A, EXECUTIVE VICE PRESIDENT

Your reference committee considered Report A of the Executive Vice President. While no items were referred for action by this House, your reference committee wishes to point out for the information of the delegates that the Executive Vice President, Mr. John F. Rineman, will become President of the American Association of Medical Society Executives in July of the coming year.

*Mr. Speaker, your reference committee recommends that Report A of the Executive Vice President be filed.*

The House approved filing of Report A of the Executive Vice President.

REPORT B, BOARD OF TRUSTEES AND COUNCILORS

Testimony presented in the reference committee hearing presented both sides of the issue. Your reference committee feels that the quality of the delegates and the alternate delegates in the past has been such that expansion of the committee to nominate delegates and alternates and the procedure proposed for selection of the committee would not necessarily improve the quality of the nominations. Further, it was the feeling of the reference committee that the increase in size might prove needlessly cumbersome.

*Mr. Speaker, your reference committee recommends rejection of the recommendation concerning the composition and procedure for selection of the Committee to Nominate Delegates and Alternates to the AMA contained in Report B of the Board of Trustees and Councilors.*

The House rejected the recommendation in Report B.

*Mr. Speaker, your reference committee recommends that the remainder of Report B of the Board of Trustees and Councilors be filed.*

The House approved filing the remainder of the report.

REPORT C, BOARD OF TRUSTEES AND COUNCILORS

The Board of Trustees and Councilors recommended a schedule of future Annual Business Meetings for the next five years. No negative testimony was heard in reference to the locations chosen by the Board of Trustees. Resolution 79-7 dealing with future sites for annual meetings of the House of Delegates was also discussed and will be reported on later in this report.

*Mr. Speaker, your reference committee recommends that the recommendation regarding future convention sites contained in Report C of the Board of Trustees and Councilors be approved.*

The House approved the recommendation in Report C.

RESOLUTION 79-7, FUTURE SITES FOR ANNUAL MEETINGS FOR THE HOUSE OF DELEGATES

*RESOLVED, That the recommendations to be considered in the selection of sites for the future House of Delegates annual meetings include a Central Pennsylvania location. The rotation then would be Philadelphia, Pittsburgh, Central Pennsylvania (location to be determined).*

Resolution 79-7 advocates the consideration of a Central Pennsylvania location in selection of sites for future House of Delegates Annual Meetings.

No negative testimony was presented concerning this resolution. There was discussion concerning the difficulties in selecting sites other than in Pittsburgh and Philadelphia which would fully meet the needs of the annual meetings.

Your reference committee feels that the testimony at the hearing justifies the amending of this resolution by making the following changes to the "RESOLVED" contained in Resolution 79-7 (items in brackets are being deleted; items underlined are being added).

*RESOLVED, That the recommendations to be considered in the selection of sites for future House of Delegates annual meetings include [a Central Pennsylvania location. The rotation then would be Philadelphia, Pittsburgh, Central Pennsylvania, (location to be determined.)] locations other than Philadelphia and Pittsburgh based on site availability and suitability.*

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-7 as amended.*

It was moved and seconded from the floor of the House that the Auxiliary be housed in the same hotel complex at annual meetings. The House approved the motion.

It was moved and seconded from the floor of the House to reconsider holding annual meetings during the week instead of weekends. The House rejected the motion.

The House adopted amended Resolution 79-7.

REPORT D, BOARD OF TRUSTEES AND COUNCILORS

Report D, Board of Trustees and Councilors, contained a recommendation suggesting the removal from the membership billing of the contribution for the Quackery Defense Fund, and further suggesting the elimination of the fund.

The report of the Board addressed the issues raised during the reference committee hearing.

*Mr. Speaker, your reference committee recommends that the recommendation regarding the removal from the membership billing of an item for the Quackery Defense Fund and elimination of the fund contained in Report D of the Board of Trustees and Councilors be approved.*

The House approved the recommendation in Report D.

REPORT A, COMMITTEE ON AID TO EDUCATION

Report A, Committee on Aid to Education, contains a recommendation for the House of Delegates to continue the support of the Educational Fund by authorizing that at least $8.00 be allocated from the 1980 annual assessment, and further recommending that each individual member support this effort by making tax deductible contributions. Overwhelming testimony in support of this recommendation was presented. The point was raised that currently 16 percent of the state's medical students depend on financial aid provided by the federal government. Your reference committee feels a need to continue the support to medical education begun over 30 years ago in Pennsylvania.

Your reference committee concurs with the testimony suggesting that the recommendation of the Committee on Aid to Education be amended in the following manner: (items in brackets are being deleted; items underlined are being added).

*The Committee on Aid to Education strongly recommends that the House of Delegates continue the support of the Educational Fund by authorizing that at least [$8.00] $10.00 be allocated from the 1980 annual assessment to continue the medical student loan program. We also urgently request that each individual member of the Society support this effort by making tax deductible contributions to this Educational and Scientific Trust.*

*Mr. Speaker, your reference committee recommends that the recommendation to continue the support of the Educational Fund contained in Report A, Committee on Aid to Education, be approved as amended.*

The House approved the recommendation in Report A.

REPORT A, COMMITTEE ON MEDICAL BENEVOLENCE

Report A, Committee on Medical Benevolence, contains a recommendation that no allocation from the annual assessment be made to the Medical Benevolence Fund. Your reference committee feels that the committee has accurately outlined a means whereby this fund should be self-sufficient for 1980 and, therefore, not require support from the annual assessment.

*Mr. Speaker, your reference committee recommends that the recommendation calling for no allocation from the annual assessment to the Medical Benevolence Fund contained in Report A, Committee on Medical Benevolence, be approved.*

The House approved the recommendation in Report A.

REPORT A, JUDICIAL COUNCIL

It was the unanimous feeling of the reference committee that Report A of the Judicial Council provides an accurate historical recording of the events concerning the chiropractic suit and of the elements of the agreement approved by the Pennsylvania Medical Society. It is further the feeling of the reference committee that the Judicial Council discharged its responsibility to the House of Delegates by its review of Report F of the Board of Trustees presented to the 1978 House of Delegates and its determination that the terms of settlement described in that report do not place physicians in an unethical position.

*Mr. Speaker, your reference committee recommends that Report A of the Judicial Council be filed.*

The House approved the filing of Report A.

RESOLUTION 79-31, PMS OPPOSITION TO AMA DIRECT BILLING

*RESOLVED, That the Pennsylvania Medical Society oppose efforts which are being put forth to permit the American Medical Association to bill individual physicians for AMA dues separately from State and County Society dues.*

Resolution 79-31 opposes the efforts by the AMA to bill physicians for AMA dues separately from state and county society dues.

Testimony provided at the reference committee hearing suggested that the billing procedures of the Pennsylvania Medical Society adequately address the problems which the proposed AMA direct billing would attempt to resolve. The testimony also favored resolution of problems of dues collection at the lowest level possible.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-31.*

The House referred Resolution 79-31 to the Board of Trustees for study.

*Mr. Speaker, your reference committee further recommends that the Pennsylvania Medical Society continue its cooperative efforts with the American Medical Association in the areas of dues collection and membership recruitment.*

The House approved the recommendation.

ADDRESS OF THE PRESIDENT ELECT, MATTHEW MARSHALL, JR., M.D.

The reference committee considered a recommendation outlined in the address of the President Elect, Matthew Marshall, Jr., M.D., calling for commendation of the AMA for its actions in the field of FTC rulings.

*Mr. Speaker, your reference committee recommends that recommendation calling for commendation of the AMA for its actions in the field of FTC rulings contained in the report of the President Elect be approved.*

The House approved the recommendation.

Dr. Marshall is to be commended for his goals and objectives as set forth in his address.

*Mr. Speaker, your reference committee recommends that the remaining portions of Dr. Marshall's address referred to Reference Committee G be filed.*

The House approved the filing of the remaining portions of the address.

ADDRESS OF THE PRESIDENT, JOHN B. LOVETTE, M.D.

In his address before the House of Delegates, we feel that Dr. Lovette accurately summarized the accomplishments of the Society during his term as president. Dr. Lovette is to be commended for his many contributions to organized medicine.

*Mr. Speaker, your reference committee recommends that the address of the President, John B. Lovette, M.D. be filed.*

The House approved the filing of the address.

RESOLUTION 79-38, FINANCIAL REIMBURSEMENT FOR LUZERNE COUNTY MEDICAL SOCIETY

*RESOLVED, That the Pennsylvania Medical Society take note of this situation and grant a reimbursement to Luzerne County Medical Society in the amount of $6,000.*

Your reference committee addressed the question presented by this resolution as to whether the expenses incurred by the Luzerne County Medical Society were in response to a request by the Pennsylvania Medical Society. The reference committee did not consider testimony concerning the dispute between the Luzerne County Medical Society and the NPW hospital development.

Based on the testimony presented, Luzerne County Medical Society acted on their own in attempting to obtain support of the Pennsylvania Medical Society in the previously mentioned dispute expending funds in an attempt to gain that support rather than in response to a request for action by the Pennsylvania Medical Society.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-38.*

The House rejected Resolution 79-38.

**Recess**

The House recessed at 5 p.m. until the opening of the final session at 8:30 a.m., Saturday, November 3.

## Thirty-Second State Dinner

Prior to the 1979 State Dinner, a reception was held in the Keystone Room of the Penn Harris Motor Inn. At 8 p.m., all those present moved to the Grand Ballroom where dinner was served. The invocation was given by Sister Margaret Mary Laitta of Mercy Hospital, Pittsburgh, Pennsylvania.

**Dinner Program**

**Introduction of dignitaries**-In order to shorten the official program of state dinner, John B. Lovette, M.D., President, dispensed with the formal introduction of the head table, guests of the Society, and his family.

**Installation of the President**-Dr. Keck installed Matthew Marshall, Jr., M.D., Allegheny County, as the 130th President of the Pennsylvania Medical Society. After taking the oath of office, Dr. Marshall introduced his family and delivered brief remarks.

**Presentation of Past President's Medallion**-Dr. Keck presented the Past President's Medallion to Dr. Lovette, Cambria County, in tribute to his great efforts on behalf of the Pennsylvania Medical Society as its 129th President.

**Presentation of Gavel to Immediate Past President of the Pennsylvania Medical Society Auxiliary**-Dr. Lovette presented the Past President's Gavel to Mrs. Howard F. Conn, Immediate Past President of the Pennsylvania Medical Society Auxiliary, in recognition of her service as President of the Auxiliary during the year ending with the 1979 Auxiliary House of Delegates.

**Adjournment**-The formal portion of the program adjourned at 10:20 p.m. Members and their guests were entertained until 12:00 p.m. by the Bob Aulenbach Orchestra.

## Final Session of the House November 3, 1979

The final session of the 1979 Annual Meeting of the House of Delegates was called to order in the Grand Ballroom of the Penn Harris Motor Inn, Camp Hill, Saturday, November 3, 1979, at 8:35 a.m.

**Committee on Credentials**

John P. Whiteley, M.D., York County, Chairman of the Committee on Credentials, presented the following report:

"Mr. Speaker, there is a quorum of 222 delegates registered and in attendance today."

### Reference Committee C
### Presented by: Robert W. Ford, MD

Mr. Speaker:

REPORT A, COUNCIL ON HEALTH PLANNING AND FACILITIES

There was no testimony on Report A of the Council.

*Mr. Speaker, your reference committee recommends that Report A of the Council on Health Planning and Facilities be filed.*

The House approved the filing of Report A.

RESOLUTION 79-34, PREPARATION AND AVAILABILITY OF "MODEL HOSPITAL MEDICAL STAFF BYLAWS" BY APPROPRIATE BODY OF THE PENNSYLVANIA MEDICAL SOCIETY

*RESOLVED, That the Annual Assembly of the Pennsylvania Medical Society direct the appropriate body to construct, with the assistance of expert legal advice, Model Rules and Bylaws for use by hospital medical staffs of Pennsylvania, to make appropriate annual revision and notify all component societies of their availability.*

The reference committee noted that the intent of Resolution 79-34 is embodied in the Council's 1980 Work Plan under the heading, "Service to Hospital Medical Staffs," Subsection "Medical Staff Bylaws."

*Mr. Speaker, your reference committee recommends that Resolution 79-34 be filed.*

The House approved the filing of Resolution 79-34.

RESOLUTION 79-47, HOSPITAL STAFF PRESIDENTS' INVOLVEMENT IN ORGANIZED MEDICINE

*RESOLVED, That a committee comprised of hospital staff presidents be formed to meet regularly at the request of the Board of Trustees.*

The reference committee noted that the 1980 Work Plan of the Council on Health Planning and Facilities indicates that the Council plans to consider a conference of hospital medical staff presidents as a means of assessing the nature and scope of services that the Council might provide hospital medical staffs. The reference committee believes the intent of Resolution 79-47 has been considered in the Council's 1980 Work Plan.

*Mr. Speaker, your reference committee recommends that Resolution 79-47 be referred to the Council on Health Planning and Facilities.*

The House referred Resolution 79-47.

RESOLUTION 79-30, HOSPICE PROGRAMS

*RESOLVED, That the Pennsylvania Medical Society endorse in principle hospice programs as an appropriate mode of care; and be it further*

*RESOLVED, That the Pennsylvania Medical Society seek changes in policies of health insurers to include subscriber coverage by third-party payors for hospice programs.*

The reference committee was informed that the Council on Health Planning and Facilities has initiated a study of the hospice concept. The reference committee concluded that it would be premature to endorse the hospice concept without further evaluation.

*Mr. Speaker, your reference committee recommends that Resolution 79-30 be referred to the Council on Health Planning and Facilities.*

The House defeated the referral of Resolution 79-30. It was moved and seconded from the floor of the House to adopt Resolution 79-30. The House adopted Resolution 79-30.

RESOLUTION 79-26, REDUCTION OF UNNECESSARY PAPERWORK, and ADDRESS OF PMS PRESIDENT ELECT, Recommendation 2

*RESOLVED, That a committee be constituted to review and reduce the amount of unnecessary hospital paperwork for physicians and nurses and that this committee be instructed to report its recommendations in resolution form at the next convention of the House of Delegates.*

Testimony supported Recommendation 2 of the President Elect and Resolution 79-26, which have similar intent.

*Mr. Speaker, your reference committee recommends approval of Recommendation 2 of the President Elect.*

The House approved Recommendation 2.

*Mr. Speaker, your reference committee recommends that Resolution 79-26 be filed.*

The House approved the filing of Resolution 79-26.

ADDRESS OF PMS PRESIDENT ELECT, Recommendation 1

The reference committee supports the intent of Recommendation 1 of the President Elect and agrees that the Society should build on its record as an advocate for the public on health issues.

*Mr. Speaker, your reference committee recommends that every unit of the Society be directed to give careful consideration to Recommendation 1 of the President Elect as we pursue our objectives in the coming year so that the Pennsylvania Medical Society is clearly recognized as a trusted and worthy advocate of the public on health issues.*

The House adopted the recommendation.

ADDRESS OF PMS PRESIDENT ELECT, Recommendation 3

The Council on Health Planning and Facilities recently initiated plans to carry out the intent of Recommendation 3 of the President Elect, that the House endorse a policy of assisting medical staffs to participate on hospital boards of directors and board committees.

*Mr. Speaker, your reference committee recommends approval of Recommendation 3 of the President Elect.*

The House approved Recommendation 3.

ADDRESS OF PMS PRESIDENT ELECT, Recommendation 4

Testimony supported the intent of Recommendation 4 of the President Elect. However, the reference committee was informed that the Council on Health Planning and Facilities has developed an education program for physicians on hospital costs and reimbursement. In addition, the PMS Board of Trustees has authorized a project to study the application of negotiating skills in the affairs of the Society. Finally, it was noted that the AMA offers a series of negotiating seminars.

*Mr. Speaker, your reference committee recommends that the portion of Recommendation 4 of the President Elect relative to hospital administration, finances and planning be referred to the Council on Health Planning and Facilities.*

The House referred Recommendation 4.

*Mr. Speaker, your reference committee recommends that the portion of Recommendation 4 of the President Elect relative to the art of negotiating be referred to the PMS Board of Trustees.*

The House referred Recommendation 4, art of negotiating.

ADDRESS OF PMS PRESIDENT, Recommendation 2

There was considerable testimony reminding the reference committee that inflationary pressures are already eroding the earning power of people in all walks of life, including physicians, leaving them with less real income. A moratorium on physicians' fees presents other problems relative to the administration of a physician's fee profile by third parties.

*Mr. Speaker, your reference committee recommends that the House of Delegates reaffirm its 1978 action urging the members of the Pennsylvania Medical Society to voluntarily pledge themselves to restrain the rate of increase in their fees so that changes in the physician fee component do not exceed any change in the Consumer Price Index on an annual basis.*

The House approved the recommendation to reaffirm.

RESOLUTION 79-5, SELF-DIAGNOSTIC HANDBOOK FOR CONSUMERS

*RESOLVED, That an appropriate body of this Society develop a self-diagnostic handbook for consumers which tells them when to call a physician, how to describe medical problems, and when to go to the emergency room; and be it further*

*RESOLVED, That this handbook be available at cost to PMS physicians who wish to furnish the handbook to consumers.*

The reference committee learned that the Council on Health Planning and Facilities is currently developing a pamphlet directed at patients to provide advice relative to the proper use of emergency rooms. A related pamphlet is also in production for distribution to physicians urging them to make adequate arrangements so their patients are informed as to how to seek services when the physician is not available. Finally, Pennsylvania Blue Shield and Capital Blue Cross have made a recent publication available entitled, "Take Care of Yourself, A Consumer's Guide to Medical Care," written by Donald M. Vickery, M.D. and James F. Fries, M.D. The reference committee concluded that additional study is necessary to properly address the intent of the resolution.

*Mr. Speaker, your reference committee recommends that Resolution 79-5 be referred to the appropriate unit of the Society for study and recommendation.*

The House referred Resolution 79-5.

RESOLUTION 79-8, HEALTH CARE SYSTEMS INCORPORATED (HSI) INTERVENTION IN OBSTETRICAL CARE AT FRANKLIN HOSPITAL, FRANKLIN, PENNSYLVANIA

*RESOLVED, That the Pennsylvania Medical Society take note of this action by the Northwest Pennsylvania HSI and that this resolution be filed for informational purposes.*

*Mr. Speaker, your reference committee recommends that Resolution 79-8 be referred to the PMS Commission on Health Planning for information.*

The House referred Resolution 79-8.

RESOLUTION 79-46, HSA PROPOSED REGULATIONS INIMICAL TO PROPER PATIENT CARE

*RESOLVED, To advise strongly the HSAs of Pennsylvania to reject the 90 percent overall hospital occupancy rate; and be it further*

*RESOLVED, That the HSAs be encouraged to reject that portion of the plan that calls for transfer of pediatric patients out of hospitals without specific pediatric units, such transfers being dependent upon medical necessity or advisability.*

The reference committee learned that the Commission on Health Planning has responsibility for handling health planning issues of this type. Since this resolution was submitted on the day of the reference committee hearing, there was no opportunity to adequately research the issue or to assess similar actions of the HSAs across the state.

*Mr. Speaker, your reference committee recommends that Resolution 79-46 be referred to the Commission on Health Planning.*

The House referred Resolution 79-46.

RESOLUTION 79-19, PMS ACTIVELY SUPPORT THE COMMONWEALTH OF PENNSYLVANIA WITH HOSPITAL DIVESTMENT EFFORTS

*RESOLVED, That the House of Delegates reaffirm and support the policy of the PMS to encourage the divestment by the State of Pennsylvania of its general hospitals, transferring ownership to nonprofit, local community groups; and be it further*

*RESOLVED, That the officers and staff of PMS be more active and forceful in encouraging prompt action by the Commonwealth of Pennsylvania in its divestment efforts.*

The reference committee concluded that the scope of this resolution was unnecessarily limited.

*Mr. Speaker, your reference committee recommends the adoption of the following substitute resolution:*

*"RESOLVED, That the House of Delegates reaffirm the policy of the Pennsylvania Medical Society calling for the divestment by the State of Pennsylvania of its general hospitals.*

The House adopted the substitute Resolution 79-19.

RESOLUTION 79-15, PRONOUNCEMENT OF DEATH IN NURSING HOMES, and REPORT F, BOARD OF TRUSTEES AND COUNCILORS

*RESOLVED, That the Pennsylvania Medical Society adopt the position that when a death occurs in a nursing home the attending physician may, via telephone or other communication, authorize the removal of the body from the nursing home; and be it further*

*RESOLVED, That the attending physician remain responsible for completion of the death certificate at the earliest convenient time, in no event longer than 96 hours after death; and be it further*

*RESOLVED, That a legal opinion be provided to the House of Delegates.*

The issue of pronouncement of death in nursing homes was debated extensively. The reference committee concluded that pronouncement of death should remain the sole responsibility of the medical profession.

*Mr. Speaker, your reference committee recommends approval of the policy statement on pronouncement of death in nursing homes as set forth in Report F of the PMS Board of Trustees.*

The House adopted the policy statement.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-15.*

The resolution was amended from the floor of the House to include "anticipated" before the word "death" in the first Resolve. The House rejected Resolution 79-15.

1979 ANNUAL REPORT OF PENNSYLVANIA MEDICAL CARE FOUNDATION

There was no testimony on the Foundation's 1979 Annual Report.

*Mr. Speaker, your reference committee recommends that the House of Delegates approve the ten (10) activities listed in the Foundation's Annual Report as the Foundation's priorities and goals for 1979-80.*

The House approved the recommendation.

REPORT H, BOARD OF TRUSTEES AND COUNCILORS

*Mr. Speaker, your reference committee recommends that Report H of the Board of Trustees and Councilors be filed.*

The House approved the filing of Report H.

RESOLUTION 79-20, DECLARATION OF INDEPENDENCE

*RESOLVED, That the Pennsylvania Medical Society approve and adopt the following "Declaration of Independence:"*

*"In view of the action by the staff of the Federal Trade Commission which would threaten the fee for service method of reimbursement of medical services, as well as the principle alternative method—the Independent Practice Association—the Pennsylvania Medical Society will continue to assert its position supporting the concept of multiple approaches to the delivery and financing of medical services. The Pennsylvania Medical Society will utilize its resources plus those of the American Medical Association and all other organizations dedicated to the preservation of competitive systems;" and be it further*

*RESOLVED, That the Pennsylvania Medical Society dedicate its resources in order to preserve this concept.*

All testimony favored adoption of this resolution.

*Mr. Speaker, your reference committee recommends that Resolution 79-20 be adopted.*

The House adopted Resolution 79-20.

RESOLUTION 79-21, PROMOTION LETTER FOR HMOs BY THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

*RESOLVED, That the Pennsylvania Medical Society call on the Department of Health, Education, and Welfare to cease mailings at government expense to medicare eligible persons, which mailings promote certain HMOs at the expense of other health care delivery systems; and be it further*

*RESOLVED, That the Department of Health, Education, and Welfare be asked to send a follow up mailing to these medicare eligibles providing them with a factually balanced statement explaining all options available to them in various health delivery systems.*

The reference committee considered the favorable testimony on this resolution and the recent action of the American Medical Association opposing the actions of the Department of Health, Education, and Welfare in its promotion of HMOs to Medicare beneficiaries.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-21.*

The House adopted Resolution 79-21.

RESOLUTION 79-45, GOVERNOR'S CONFERENCE ON HMOs

*RESOLVED, That the Pennsylvania Medical Society immediately provide for the Commonwealth of Pennsylvania all of the facts regarding the cost-effectiveness of HMOs; and be it further*

*RESOLVED, That the information developed in a recent AMA study on HMOs be secured for analysis; and be it further*

*RESOLVED, That the Pennsylvania Medical Society investigate the source or sources of the government's information, including its accuracy, and investigate the reasons for convening the HMO Conference; and be it further*

*RESOLVED, That the Pennsylvania Medical Society begin a dialogue with the Governor to acquaint him with the advantages and disadvantages of HMOs in all respects.*

Testimony favored adoption of this resolution.

The reference committee accepted a revision from the author, which inserts the word "Governor" for the words "Commonwealth of Pennsylvania" on line 2 of the first "Resolved"; and inserts the word "Governor's" for the word "government's" on

line 2 of the third "Resolved."

*Mr. Speaker, your reference committee recommends that Resolution 79-45 be adopted as amended and referred to the Pennsylvania Medical Care Foundation for appropriate action.*

The House approved the amendments to Resolution 79-45. The House adopted and referred amended Resolution 79-45.

## Annual Meeting Pennsylvania Medical Care Foundation

As in past years, the annual meeting of the Pennsylvania Medical Care Foundation was held during the 1979 House of Delegates meeting and proceeded as follows:

"The Chair believes it wise to take a minute to be certain that all members of the House understand how we will consider the next order of business. We wish to convene the annual meeting of the administrative members of the Pennsylvania Medical Care Foundation.

"According to the Foundation's Bylaws, 'Administrative members shall consist of those persons who are duly qualified and elected delegates to the House of Delegates of the Pennsylvania Medical Society.' The Bylaws further state, 'The acceptance of election as a delegate to the House of Delegates of the Pennsylvania Medical Society by an eligible physician shall be determined to be acceptance of administrative membership in this corporation and an intention to be bound by the articles of Incorporation and Bylaws of the Corporation unless the delegate otherwise notifies the Secretary of the Corporation prior to the Annual Meeting.'

"In other words, the voting members of the House are also the administrative members of the Foundation.

"At this time, the Chair will entertain a motion to recess the meeting of the PMS House of Delegates and to convene the administrative members of the Pennsylvania Medical Care Foundation in the Annual Meeting of the Foundation.

"The Chair recognizes the President of the Pennsylvania Medical Care Foundation, Dr. Joseph Demko. Dr. Demko . . ."

Following remarks by Dr. Demko, the meeting proceeded as follows.

"Thank you, Don. While it's true that we are sitting now as the administrative members of the Pennsylvania Medical Care Foundation, I am sure that all of us want to expedite the business of the Foundation as quickly as possible. I believe this can best be achieved if we permit an experienced hand to guide us from the Speaker's rostrum. For that reason, I would respectfully ask the permission of the administrative members to have Dr. Harrop serve as acting Speaker of the Foundation so that he may use his skill in parliamentary matters . . . Hearing no objections, Dr. Harrop, I ask you to take over."

"Thank you, Joe. The first item of business for the administrative members of the Foundation is consideration of the Annual Report of the Foundation, which has just been dealt with in the Report of Reference Committee C. If there are no further actions or comments concerning this annual report, the Chair will entertain a motion to file the report as presented.

"It is filed.

"The second item of business this year for the administrative members of the Foundation is the election of five directors. The Board of Directors of the Foundation presents the following nominees for the vacancies. The Foundation's Bylaws also allow for additional nominations to be made from the floor by any administrative member for all vacancies at the time of the elections.

| *Vacancy* | *Nominee* | *County* |
|---|---|---|
| A-1 | Roland A. Loeb, MD | Lancaster |
| A-2 | William P. Garvey, MD | Erie |
| A-3 | Robert E. Davis, MD | Allegheny |
| A-4 | Frans J. Vossenberg, MD | Montgomery |
| A-5 | Bernard B. Zamostien, MD | Philadelphia |

"In the event there is a contest for one of the Foundation's slots, the contest will be added to the PMS ballot and delegates will cast their vote tomorrow morning."

*(Secretary's Note: There were no nominations from the floor and the nominees above were elected.)*

"Is there any further Foundation business? If not, the Chair will entertain a motion to adjourn the meeting of the Foundation and to reconvene the PMS House."

## Reference Committee D
## Presented by: Frederick G. Brown, MD

Mr. Speaker, members of the House of Delegates:

REPORT A, COUNCIL ON LEGISLATION

The committee heard testimony from the Chairman of the Council on Legislation, Dr. R. William Alexander, who expressed pleasure in the way the Society's legislative program is proceeding. We feel that Dr. Alexander and the members of the Council on Legislation are to be commended for their activities thus far in the 1979-80 legislative session.

*Mr. Speaker, your reference committee recommends that Report A of the Council on Legislation be filed.*

The House approved the filing of Report A.

REPORT B, COUNCIL ON LEGISLATION

Report B of the Council is a report of legislation that the Council and the Board of Trustees have considered thus far in the first half of the 1979-80 session of the Pennsylvania General Assembly. Questions were received by persons in the audience about specific bills. One bill not appearing on the list was called to the reference committee's attention. This proposal would transfer the Scranton State Hospital to the community and your reference committee recommends that it be added to the list in keeping with the Society's long-standing policy of returning the state-owned general hospitals to their respective communities. This report, as does Report A, reflects good progress in our legislative program.

*Mr. Speaker, your reference committee recommends that Report B of the Council on Legislation be filed.*

The House approved the filing of Report B.

ADDRESS OF PMS PRESIDENT, Recommendation 1

Your reference committee recognizes that President Lovette has obviously given the matter of chiropractic encroachment a great deal of thought. We agree with him in his conclusions.

*Mr. Speaker, your reference committee recommends that Recommendation 1 in the Address of the President be referred to the Council on Legislation.*

The House referred Recommendation 1.

RESOLUTION 79-1, NATIONAL HEALTH INSURANCE - PILOT PROGRAM

*RESOLVED, That the Pennsylvania Medical Society put forth every effort to assure that any National Health Insurance Program, before full implementation, be tested on a pilot project basis; and be it further*

*RESOLVED, That the American Medical Association be requested to join PMS in this effort.*

Your reference committee heard conflicting testimony on this resolution. We heard a concerned explanation from the author, Robert S. Pressman, MD. We also heard testimony that the press and legislators might misconstrue our support of pilot programs in this area. These were persuasive. The committee was also reminded that "pilots" are all around us in the form of Medicare, Medicaid, End Stage Renal Dialysis programs, as well as

socialized programs in other countries. We see no need to endorse pilot programs even when national health insurance seems inevitable, which it does not this year.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-1.*

The House accepted the editorial change to add, "if approved by the U.S. Congress" after "National Health Insurance Program" in the first Resolve. The House adopted Resolution 79-1.

RESOLUTION 79-4, PODIATRY

*RESOLVED, That PMS seek legislative action to clarify the Podiatry Act so as to prohibit podiatrists from treating any condition that is not confined to the foot.*

Your committee heard from the author of Resolution 79-4. It should be noted that the author is also the Medical Director of the Department of Public Welfare of the State of Pennsylvania, Dr. O. K. Stephenson, who shared with us his concern that podiatrists in some instances are in fact practicing medicine and are prescribing drugs which will impact on more than just minor foot ailments. Dr. Stephenson seemed to agree that instead of immediately asking legislative relief without all of the facts available, the Society should get more information on the present practice activities of podiatrists.

*Mr. Speaker, accordingly we recommend that the resolved portion be amended as follows: Resolved, That the Board of Trustees assign the appropriate council or committee of the Society to get a clarification of the intent of the Podiatry Practice Act through meetings with representatives of the Podiatry Board, their teaching institutions, and their Association and to report to the next meeting of the House as to what legislative remedies may be needed.*

The House approved amended Resolution 79-4.

RESOLUTION 79-29, REPEAL OF ACT 111

*RESOLVED, That the Pennsylvania Medical Society fight for repeal of Act 111.*

The reference committee, in considering Resolution 79-29, heard from the introducer of the resolution that perhaps the author had gone further in recommending repeal of Act 111 then he intended. Dr. Lecher pointed up several problems that the author experienced in serving on an arbitration panel. The reference committee's attention was called to many of the remedial amendments which the Society is considering, some of which are aimed at solving the problems brought forth. Your reference committee feels that this Society is on the proper course in pursuing the amendments under consideration.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-29.*

The House rejected Resolution 79-29.

RESOLUTION 79-33, FLUORIDATION

*RESOLVED, That the Pennsylvania Medical Society take the necessary steps to sponsor legislation to make this public health measure a state law.*

The reference committee was reminded of the long-standing support that the Pennsylvania Medical Society has given to the fluoridation of public water supplies. It was also reminded that recently the Society has testified against a proposal which would prohibit the statewide fluoridating of public water supplies; this testimony was presented as recently as three weeks ago before the Senate Health and Welfare Committee. We do not believe under the present circumstances that it would be profitable for us to initiate legislation to require fluoridation of public water supplies through the state. We prefer that this Society, as it did in testifying before the Health and Welfare Committee, continue to call for fluoridation and continue to urge communities to fluoridate as they are now permitted by law to do.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-33.*

The House rejected Resolution 79-33.

RESOLUTION 79-39, MORATORIUM ON MEDICAL SCHOOL TUITION INCREASES

*RESOLVED, That the Pennsylvania Medical Society support an indefinite moratorium on tuition increases at the state medical schools; and be it further*

*RESOLVED, That it will actively strive to halt these tuition increases by trying to attain more funding to aid students directly, as financial aid, and indirectly, in the form of capitation fees, from both the state and federal governments.*

Resolution 79-39 was considered with the other two which follow; all three Resolutions 79-39, 79-40, and 79-41 were introduced by medical students. It is apparent to your reference committee that the problem with medical school tuition and the yearly increases have become a problem of major concern, not only to students, but to organized medicine. The problem is literally approaching crisis proportions and should be given top priority consideration by the Society. The reference committee, in considering Resolution 79-39 and hearing testimony from Mr. Landucci, determined that we cannot in good conscience support a moratorium on tuition increases. Rather, in support of our future colleagues, we should demand from the schools themselves the rationale behind tuition increases and further demand notification of tuition increases far enough in advance that the students may prepare for it. Accordingly, your reference committee recommends substitute Resolution 79-39 with the following change in subject and resolved.

*Mr. Speaker, the subject of Substitute Resolution 79-39 should be "Medical School Tuition Increases" and the resolve portion, "Resolved, that the Society will request from the schools on an annual basis detailed information on any tuition increases imposed by the school."*

A second substitute Resolution 79-39 from the floor of the House was rejected. The House adopted substitute Resolution 79-39.

RESOLUTION 79-40, LOAN FORGIVENESS TO PROVIDE MEDICAL PERSONNEL REDISTRIBUTION

*RESOLVED, That the Pennsylvania Medical Society will seek the introduction of legislation providing a program of loan forgiveness to medical school graduates who establish necessary practices (presumably primary care) in underserved areas of the state, the amount of forgiveness being directly proportional to the extent of service.*

Your reference committee will recommend adoption of Substitute Resolution 79-40, the new subject of which is to be "Loan Forgiveness."

*Mr. Speaker, we recommend the following substitute resolved, "That the Medical Society will continue to support legislation providing a program of loan forgiveness to medical school students who establish necessary practices in underserved areas of the state, the amount of forgiveness being directly proportional to the duration of service."*

The House adopted substitute Resolution 79-40.

RESOLUTION 79-41, INCREASE IN STATE LOAN AMOUNTS TO MEDICAL STUDENTS

*RESOLVED, That the Pennsylvania Medical Society will seek to have the limits for annual loans and for the cumulative loan amount obtainable from PHEAA increased.*

The reference committee heard testimony that the Society is in fact supporting legislation currently before the General Assembly to increase the amount of loans from the Pennsylvania Higher Education Assistance Agency (PHEAA). Your committee also heard testimony from the Director of the Educational and Scien-

tific Trust who reported what we consider to be a good record of lending money to students. We are sure that the Trust could use more money and your committee would recommend that the Trust investigate avenues for obtaining more funds from physicians. For instance, it might be worthwhile to arrange for money to be loaned to the Trust for a period of years from physicians who might benefit from tax savings by so doing. Obviously, your reference committee did not have time to go into great depth but feels that it should be investigated by the Trust.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-41.*

The House adopted Resolution 79-41.

RESOLUTION 79-44, SCHOOL TREATMENT OF INSECT BITE ALLERGIC CHILDREN

*RESOLVED, That the Pennsylvania Medical Society seek amendments to the appropriate legislation to permit registered nurses, teachers, and principals to give medication by injection and orally per order of the physician and authorization of parents or guardians.*

Your reference committee feels that Resolution 79-44, appropriately handled at the school level, would be very worthwhile. Accordingly, we are recommending the adoption of Substitute Resolution 79-44 as follows:

*Mr. Speaker, "Resolved that the Pennsylvania Medical Society seek either amendments or regulations to permit registered nurses or appropriately trained teachers to give medication by injection and orally on order of the physician and authorization of parent or guardian."*

The House adopted substitute Resolution 79-44.

## Reference Committee F
## Presented by: Jon S. Adler, MD

Mr. Speaker, members of the House of Delegates:

REPORT A, COUNCIL ON MEMBER SERVICES and RESOLUTION 79-11, PARTICIPATION IN THE PMS CREDIT UNION

*RESOLVED, That every member of the Pennsylvania Medical Society be encouraged by this resolution to participate in the credit union and that they encourage their employees to do likewise; and be it further*

*RESOLVED, That all county medical societies be urged by this resolution to consider investing a portion of their reserve monies in the credit union so that their members can be better served by this unique benefit.*

Since a portion of the Council report and the resolution deal with a similar subject, the reference committee considered them as one. The reference committee heard only favorable testimony in regard to urging participation in the PMS Credit Union by PMS members, their employees and families, as well as county medical societies. The reference committee is pleased with the growth in this new member benefit and believes it would be advantageous for county societies to invest reserves both for the benefit of the credit union and for the county society members who will be better served by the credit union as a result. Resolution 79-11 is broader in its intent than the recommendation in the Council's annual report and the reference committee favors that concept.

*Mr. Speaker, Reference Committee F recommends that Resolution 79-11 be adopted in lieu of the recommendation presented in Report A, Council on Member Services.*

The House adopted Resolution 79-11 in lieu of the recommendation presented in Report A.

The remainder of the Council's annual report was informational. The reference committee is impressed with the Council's efforts to increase PMS and AMA membership as well as efforts to improve and consolidate member services and benefits. The reference committee commends the Council and its staff for the past year's activities and thanks the Council members for their service.

*Mr. Speaker, Reference Committee F recommends that the annual report of the Council on Member Services be filed.*

The House approved the filing of the annual report (Report A).

WAIVER OF DEBATE

The following items have been grouped together in a waiver of debate list; in each case, little or no testimony was heard and the committee feels the items are of a non-controversial nature.

Report A, Resident Physician Section (file)
Report A, Advisory Committee to the PMS Auxiliary (file)
Address of the President, PMS Auxiliary (file)
Address of the President, Pennsylvania Medical Cooperative (file)

The reference committee praises Mrs. Conn for her year of outstanding leadership and for her impressive remarks to the House. The reference committee extends its appreciation to the entire Auxiliary for its support of organized medicine.

The reference committee thanks Dr. Cooper and his Board for their efforts in attempting to make the Co-op a viable member benefit. We would like to encourage all PMS members to take advantage of our Co-op to whatever extent possible.

*Mr. Speaker, Reference Committee F recommends that the above items be filed.*

The House approved the filing of the waiver of debate items.

REPORT G, BOARD OF TRUSTEES AND COUNCILORS

The reference committee heard no comments in regard to Report G. Therefore, it is suggested that there be no change in policy with respect to financial support for AMSA chapters in Pennsylvania at this time.

*Mr. Speaker, Reference Committee F recommends adoption of Report G, Board of Trustees and Councilors, in lieu of Resolution 78-2.*

The House adopted Report G in lieu of Resolution 78-2.

RESOLUTION 79-24, SOCIETY-SPONSORED INSURANCE/ LAPSES BY MEMBERS

*RESOLVED, That Pennsylvania Medical Society organize an agreement with the agents of PMS-sponsored group insurance plans so that no member's policy should be allowed to lapse unless the member declares that the lapse is intentional.*

The reference committee heard mixed testimony in regard to this resolution. It was agreed that a physician should receive adequate notification of a pending lapse in coverage. It was also agreed that it would not be practical for insurance coverage to be maintained or responsibility be given to our vendors to continue coverage simply because a physician does not respond to a lapse notice. After discussion it was determined that currently there appears to be no problem with the State Society sponsored insurance programs.

*Mr. Speaker, Reference Committee F recommends rejection of Resolution 79-24.*

The House rejected Resolution 79-24.

ADDRESS OF THE PRESIDENT, PMS, RECOMMENDATION 3

The reference committee was in sympathy with Dr. Lovette's recommendation and calls on each county medical society to review its procedures for accepting new members.

*Mr. Speaker, Reference Committee F recommends that each county medical society review its procedures for accepting new members.*

The House approved the recommendation.

ADDRESS OF THE PRESIDENT ELECT, PMS, RECOMMENDATION 6

The committee heard no opposition to the recommendation for continuing the drive to recruit AMA members and adopting unified membership.

*Mr. Speaker, Reference Committee F recommends adoption of Recommendation 6 of the address of the President Elect.*

The House adopted the recommendation. The following motion was made from the floor of the House: "Unified membership be mandatory and that the Standing Committee on Constitution and Bylaws be directed to prepare appropriate language to effect the changes necessary for presentation to next year's House." It was seconded. The House adopted the recommendation.

ADDRESS OF THE PRESIDENT ELECT, PMS, RECOMMENDATION 7

The committee heard no adverse remarks in regard to the recommendation calling for PMS to recruit osteopathic physicians into membership.

*Mr. Speaker, Reference Committee F recommends adoption of Recommendation 7 of the address of the President Elect.*

The House adopted Recommendation 7.

## Reference Committee E
## Presented by: Robert E. Gregory, MD

Mr. Speaker and members of the House of Delegates:

Your reference committee has grouped the following items together in a Waiver of Debate list. In each instance, there was little or no testimony heard and the committee feels these items are of a non-controversial nature.

Report A, Council on Medical Economics (filed)
Report E, Board of Trustees and Councilors (filed)
PMSLIC Annual Report (filed)
Pennsylvania Blue Shield Annual Report (filed)
Resolution 79-12, Equitable Risk Classifications in Medical Liability Premiums (filed)

*RESOLVED, That the Pennsylvania Medical Society support the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.*

*Mr. Speaker, your reference committee recommends that the above items be filed.*

The House approved the filing of the waiver of debate items.

RESOLUTION 79-10, REFUNDING THE MANDATORY ASSESSMENT PAID TO FUND PMSLIC

*RESOLVED, That the mandatory assessment be refunded to those who have paid it before any new PMSLIC insureds are excused from payment of the assessment.*

The reference committee heard very few comments regarding this resolution. In view of a Policyholders Indenture dated January 1977, it would be impossible to implement any refund until December 1, 1982.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-10.*

The House rejected Resolution 79-10.

RESOLUTION 79-16, PMS EVERY MEMBER MANDATORY ASSESSMENT

*RESOLVED, That the Board of Trustees of the Pennsylvania Medical Society review and report back to the House of Delegates such means as may be appropriate to return the assessment to those members who paid the assessment in support of the Society's goals.*

Although there was little testimony on this resolution, concern was expressed regarding this option and it was felt that this should be further considered by the PMS Board of Trustees, thus:

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-16.*

The House adopted Resolution 79-16.

RESOLUTION 79-6, COMPOSITION OF THE PMSLIC BOARD

*RESOLVED, That the present policy of electing the entire board of PMSLIC annually be continued; and be it further*

*RESOLVED, That at least three members of the board of PMSLIC shall come from the Board of Trustees, chairmen of councils, speaker and vice speaker of the House of Delegates, secretary, vice president, president elect, president, immediate past president, or executive vice president of the Pennsylvania Medical Society.*

Your reference committee heard testimony supporting a close working relationship between the Boards of PMS and PMSLIC. Concern was voiced, however, that more continuity of PMSLIC's Board might be in order; this is to be accomplished through election of a portion of PMSLIC's Board on an annual basis. Your reference committee thus recommends that the first resolve be amended to read...

*RESOLVED, That the present policy of electing the entire Board of PMSLIC annually be referred to the PMS Board of Trustees and the PMSLIC Board of Directors to consider the election of one-third of the PMSLIC Board annually.*

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-6 as amended.*

The House adopted amended Resolution 79-6. A motion made from the floor of the House to reconsider was defeated.

RESOLUTION 79-17, PMS OPPOSE "APPROPRIATENESS OF CARE" DETERMINED BY NON-MEDICAL PERSONNEL

*RESOLVED, That the Pennsylvania Medical Society oppose the intrusion of third-party payers into the clinical doctor-patient relationship; and be it further*

*RESOLVED, That the Pennsylvania Medical Society object to the unilateral determination, by nonmedical personnel, of "Medical Appropriateness"; and be it further*

*RESOLVED, That organized medicine and academic medicine work conjointly to develop fair and satisfactory indications for or against procedures and that these recommendations be used to determine the liability of third-party payers.*

Your reference committee heard testimony assuring us that Blue Shield does seek physician input and advice before declaring some diagnostic and other procedures inappropriate. Procedures of questionable value are reviewed by Blue Shield medical advisors (all physicians), the Medical Advisory Committee (75% physicians), and the Board of Directors (50% physicians) before any decision is made. The reference committee is in agreement with the intent of the resolution.

*Mr. Speaker, your reference committee recommends that Resolution 79-17 be filed.*

The House approved the filing of Resolution 79-17.

RESOLUTION 79-22, OUTPATIENT CHEMOTHERAPY

*RESOLVED, That the Pennsylvania Medical Society urge third party carriers who include chemotherapy in their benefit packages to offer the option of providing the chemotherapy on either an inpatient or outpatient basis.*

Your reference committee heard testimony that Pennsylvania Blue Shield, in cooperation with the Blue Cross of Lehigh Valley (Allentown), has initiated an experimental pilot project wherein drugs, office visits and laboratory studies will be reimbursed to subscribers undergoing outpatient chemotherapy.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-22.*

The House adopted Resolution 79-22.

RESOLUTION 79-23, THIRD PARTY PAYMENT MECHANISM

*RESOLVED, That the Pennsylvania Medical Society meet with Blue Shield to see if an option to accept or refuse assignment may be extended to participating physicians; and be it further*

*RESOLVED, That the Pennsylvania Medical Society meet with Blue Shield and other medicare intermediaries to see if payments to subscribers can be restricted to bills accompanied either by a receipted bill or a release from the provider; and be it further*

*RESOLVED, That the Pennsylvania Medical Society make efforts directly and through the American Medical Association to preserve the option for providers to accept or refuse assignment on a claim-by-claim basis.*

There was spirited and conflicting testimony relative to this resolution, particularly as to additional cost to third party payors, patient confusion in regard to billing, and the inability to properly implement this resolution. The testimony appeared to favor further study. Thus,

*Mr. Speaker, your reference committee recommends that Resolution 79-23 be referred to the Council on Medical Economics for further study.*

The House referred Resolution 79-23.

RESOLUTION 79-25, MEDICARE CO-INSURANCE COLLECTION

*RESOLVED, That the Pennsylvania Medical Society meet with representatives of the Hospital Association of Pennsylvania and medicare carriers and intermediaries to see if proposals can be agreed upon to secure equality of treatment of co-insurance payments regardless of the type of provider who provides the services.*

Your reference committee heard considerable testimony on the differences between the cost accounting systems used in hospitals and accounting methods employed by physicians in private practice. Medicare regulations provide for a hospital to write off Part A bad debts after a reasonable collection effort. Medicare Part B regulations for physician services do not recognize bad debts as an allowance.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-25.*

A motion was made from the floor of the House to refer Resolution 79-25 to the appropriate council. It was seconded. The House referred Resolution 79-25.

RESOLUTION 79-37, NORTHEAST PENNSYLVANIA BLUE CROSS

*RESOLVED, That this House reaffirm the 1978 action and direct the Board to actively work to assure that Northeastern Pennsylvania Blue Cross will henceforth make available to all hospital-based members the option for payment by fee-for-service if they request it; and be it further*

*RESOLVED, That if this result is not otherwise obtainable, the Pennsylvania Medical Society Board of Trustees should take appropriate legal action.*

Your reference committee heard testimony that Northeast Pennsylvania Blue Cross is the only Blue Cross plan in Pennsylvania that denies hospital-based physicians the right to fee-for-service reimbursement. One area hospital did obtain exception to this rule through legal action. No legal precedent has been set, however, and the Plan (Blue Cross) has refused to enter into other such agreements with hospitals in the same service area.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-37.*

The House adopted Resolution 79-37.

RESOLUTION 79-18, DEPARTMENT OF PUBLIC WELFARE REIMBURSEMENT

*RESOLVED, That the Pennsylvania Medical Society pursue legal action to obtain prevailing fee compensation for both office and hospital based service for medicaid patients; and be it further*

*RESOLVED, That this action be instituted no later than January 1, 1980; and be it further*

*RESOLVED, That if legal recourse is not available, then the Pennsylvania Medical Society may function as advising agent to practicing physicians in the pursuit of other possible recourses.*

The reference committee heard considerable testimony relative to the inadequacy of the Medical Assistance physicians' reimbursement and the constant inability to achieve negotiations that might increase this reimbursement schedule. The advisability of seeking legal action against the Department of Public Welfare was questioned in light of the fact that the Legislature does provide the funds for the DPW budget. It was suggested that legal action be taken against the Department of Public Welfare but this approach was deemed inadvisable.

*Mr. Speaker, your reference committee recommends rejection of Resolution 79-18.*

The House rejected Resolution 79-18.

RESOLUTION 79-43, PENNSYLVANIA DPA REIMBURSEMENT

*RESOLVED, That the PMS commit itself again to the principles of quality private medical care to all and encourage each member of the State Society to take his/her share of Medical Assistance patients to create one class of medical care in the Commonwealth; and be it further*

*RESOLVED, That the PMS create an ongoing working committee to continuously work with representatives of the Department of Public Assistance and the state legislature until a new, equitable fee structure for physicians is achieved and give members of PMS compatible reimbursement with hospitals; and be it further*

*RESOLVED, That the House of Delegates of the PMS authorize and mandate the Board of Trustees of the PMS to take all actions, legal if necessary, to achieve equality in reimbursement to private physicians by DPA if negotiations by the working committee fail within 12 months.*

In the testimony it was noted that the new personnel within the Department of Public Welfare have been more receptive and will reconsider the physician reimbursement problem. This is to be done on a continuing basis. It was felt this should be done through the Council on Medical Economics. It was, however, suggested that these efforts must be vigorous and continuous to satisfy the tenor of the testimony from this House of Delegates.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-43.*

The House adopted Resolution 79-43.

RESOLUTION 79-42, DPA MEDICAID FRAUD INVESTIGATION

*RESOLVED, That the PMS express its concern about this step by the Department of Public Assistance and the Governor's Office at a time when the PMS tries to establish close working relationships with both offices; and be it further*

*RESOLVED, That the House of Delegates ask the Board of Trustees of the PMS to send a strong letter of protest to the above offices requesting that these types of gestapo practices be stopped and the existing methods against fraud and abuse be used with all their legal force.*

Your reference committee heard considerable testimony relative to this resolution and the telegram from Gerald Radke, Deputy Secretary of the Department of Public Welfare. A general feeling of total dismay among the delegates was noted and a vigorous rebuttal to such a defamatory attack was suggested. In view of this, the committee recommends that the second resolve be amended. The amended resolve would read . . .

*RESOLVED, That the House of Delegates ask the Board of Trustees of the PMS to respond immediately and vigorously to the Department of Public Welfare, the Governor's Office, and the Department of Justice strongly protesting the divisive content of Gerald Radke's telegram of October 26, 1979, which had been sent to Regional Deputy Secretaries, county Assistance Offices,*

*and Medical Assistance recipients and insisting that this type of defamatory practice be stopped. In addition, state government agencies should make better use of existing methods to combat fraud and abuse within the Medical Assistance Program, rather than a frontal attack on physician providers.*

Your reference committee, reflecting the testimony heard, recommends that a third resolve be added to this resolution. The third resolve would read . . .

*RESOLVED, That the action taken on this resolution and the response received from the state agencies identified herein be transmitted to the PMS membership as soon as possible.*

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-42 as amended.*

The House accepted the editorial change adding "the Secretary of Health" after "the Governor's Office" in the first Resolve. The House adopted amended Resolution 79-42 with the editorial change.

RESOLUTION 79-48, PROPOSED DPW PROVIDER AGREEMENT

*RESOLVED, That PMS immediately notify the Department of Public Welfare that this proposed agreement is totally unacceptable.*

The reference committee heard spirited testimony overwhelmingly against this Provider Agreement prepared by the Department of Public Welfare and the Department of Justice.

*Mr. Speaker, your reference committee recommends adoption of Resolution 79-48.*

The House adopted Resolution 79-48.

## Annual Assessment

Kenneth L. Cooper, M.D., Chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report containing the recommendation of the Finance Committee that the annual assessment for full dues-paying members remain at $225 for 1980.

"Mr. Speaker, members of the House of Delegates, at the first session of this House, I presented to you a detailed report on the 1980 budget which projected a deficit of $187,050. I also mentioned that a few changes had been made after the presentation had been prepared. These changes resulted in an anticipated deficit of $201,905.

"After reviewing the actions of the House these past few days, we noted that the recommendation to increase the allocation to the Educational and Scientific Trust from $8 to $10 was the only item which significantly impinges on the 1980 budget. This increase of $2.00 has the effect of increasing the deficit by approximately $22,000 or a total of $223,905.

"Anticipating a sizable surplus for 1979, the Board of Trustees recommends that the dues for 1980 remain at $225.

"Contingent upon the approval by the House of the 1979 assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 4.44 percent of the annual assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which in the case of full dues-paying members will amount to $10.

"This means that $215 of the annual assessment of each full dues-paying member will be available to the General Fund for operating expenses of the Society."

The Speaker announced that the Board of Trustees would reconvene for its reorganization meeting in Keystone A immediately following the adjournment of the House of Delegates.

A motion was made from the floor of the House to give Dr. Witt a vote of thanks. This motion was seconded. The House approved the recommendation.

It was moved and seconded that the House of Delegates be adjourned. The House adjourned at 11:10 a.m.

Respectfully submitted,

| | |
|---|---|
| D. Ernest Witt, MD<br>Speaker | G. Winfield Yarnall, MD<br>Secretary |
| Donald E. Harrop, MD<br>Vice Speaker | Barbara M. Geisel<br>Assistant Secretary |

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Resolutions

51 79-1 (Referred to Reference Committee D), Subject: National Health Insurance-Pilot Program, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: Robert S. Pressman, MD, on behalf of the Philadelphia County Medical Society.

45 79-2 (Referred to Reference Committee B), Subject: Referendum for PMS Policy on Abortion, Introduced by: Denis A. Boyle, MD, Chester County Medical Society, Author: Gerald L. Andriole, MD, Trustee and Councilor, Twelfth Councilor District.

44 79-3 (Referred to Reference Committee B), Subject: Safety Standards for Nuclear Power Facilities, Introduced by: Roland A. Loeb, MD, Secretary, on behalf of the Lancaster City and County Medical Society, Author: The Board of Directors of the Lancaster City and County Medical Society.

52 79-4 (Referred to Reference Committee D), Subject: Podiatry, Introduced by: Paul Karlik, Jr., MD, Secretary, on behalf of the Perry County Medical Society, Author: O. K. Stephenson, MD, President, on behalf of the Perry County Medical Society.

49 79-5 (Referred to Reference Committee C), Subject: Self-Diagnostic Handbook for Consumers, Introduced by: Paul Karlik, Jr., MD, on behalf of the Perry County Medical Society, Author: O. K. Stephenson, MD, President, on behalf of the Perry County Medical Society.

54 79-6 (Referred to Reference Committee E), Subject: Composition of the PMSLIC Board, Introduced by: Howard L. Carbaugh, MD, Secretary, on behalf of the Lehigh County Medical Society, Author: Lehigh County Medical Society.

47 79-7 (Referred to Reference Committee G), Subject: Recommendations for Future Sites for Annual Meetings of the House of Delegates, Introduced by: Arlington A. Nagle, MD, Secretary, on behalf of the Berks County Medical Society, Author: Arlington A. Nagle, MD.

49 79-8 (Referred to Reference Committee C), Subject: Health Systems Incorporated (HSI) Intervention in Obstetrical Care at Franklin Hospital, Franklin, Pennsylvania, Introduced by: John A. Emerson, MD, Venango County Medical Society, Author: John A. Emerson, MD.

44 79-9 (Referred to Reference Committee B), Subject: "1985 Proposal," Introduced by: Conrad A. Etzel, MD, on behalf of the Delaware County Medical Society, Author: Delaware County Medical Society.

54 79-10 (Referred to Reference Committee E), Subject: Refunding the Mandatory Assessments Paid to Fund PMSLIC, Introduced by: John T. McGeehan, MD, Elk-Cameron County Medical Society, Author: M. Vernon Ordiway, MD, Elk-Cameron County Medical Society.

53 79-11 (Referred to Reference Committee F), Subject: Participation in the Pennsylvania Medical Society Credit Union, Introduced by: William A. Shaver, MD, Secretary, Lebanon County Medical Society, Author: William A. Shaver, MD.

54 79-12 (Referred to Reference Committee E), Subject: Equitable Risk Classifications in Medical Liability Premiums, Introduced by: James R. Regan, MD, on behalf of the Pennsylvania Society of Internal Medicine, Author: Pennsylvania Society of Internal Medicine.

45 79-13 (Referred to Reference Committee B), Subject: Judicial Council of the American Medical Association Reconsider its Previous Abortion Interpretation, Introduced by: John D. Lane, MD, Bucks County Medical Society, Author: John D. Lane, MD and Samuel S. Faris, MD, Montgomery County Medical Society.

44 79-14 (Referred to Reference Committee B), Subject: PMS Oppose Performance of Medical Procedures Without Specific Advance Arrangements with a Properly Qualified Medical Practitioner, Introduced by: James E. Bauer, MD, Secretary, on behalf of the Armstrong County Medical Society, Author: Armstrong County Medical Society.

50 79-15 (Referred to Reference Committee C), Subject: Pronouncement of Death in Nursing Homes, Introduced by: Ralph Gaudio, Jr., MD, Secretary, Allegheny County Medical Society, Author: Robert J. Carroll, MD, Allegheny County Medical Society.

54 79-16 (Referred to Reference Committee E), Subject: 1977 PMS Every Member Mandatory Assessment, Introduced by: Ralph Gaudio, Jr., MD, Secretary, Allegheny County Medical Society, Author: Howard A. Mermelstein, MD, President, Allegheny County Medical Society.

54 79-17 (Referred to Reference Committee E), Subject: PMS Oppose "Appropriateness of Care" Determined by Non-Medical Personnel, Introduced by: Norman A. Goldstein, MD, Secretary, Chester County Medical Society, Author: John P. Maher, MD, Chester County Medical Society.

55 79-18 (Referred to Reference Committee E), Subject: Department of Public Welfare Reimbursement, Introduced by: David L. Kerstetter, MD, Bedford County Medical Society, Author: David L. Kerstetter, MD.

50 79-19 (Referred to Reference Committee C), Subject: PMS Actively Support the Commonwealth of Pennsylvania in its Hospital Divestment Efforts, Introduced by: John C. Cottrell, MD, on behalf of the Berks County Medical Society, Author: Berks County Medical Society.

50 79-20 (Referred to Reference Committee C), Subject: Declaration of Independence, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: Sidney O. Krasnoff, MD, Philadelphia County Medical Society.

50 79-21 (Referred to Reference Committee C), Subject: Promotion Letter for HMOs by the Department of Health, Education and Welfare, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: Peter A. Theodos, MD.

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54 79-22 (Referred to Reference Committee E), Subject: Outpatient Chemotherapy, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: David M. Sklaroff, MD, Philadelphia County Medical Society.

55 79-23 (Referred to Reference Committee E), Subject: Third Party Payment Mechanism, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: George R. Fisher, MD.

53 79-24 (Referred to Reference Committee F), Subject: Society-Sponsored Insurance/Lapses by Members, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: George R. Fisher, MD.

55 79-25 (Referred to Reference Committee E), Subject: Medicare Coinsurance Collection, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: George R. Fisher, MD, Philadelphia County Medical Society.

49 79-26 (Referred to Reference Committee C), Subject: Reduction of Unnecessary Paperwork, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: David S. Cristol, MD.

43 79-27 (Referred to Reference Committee B), Subject: Use of Non-Physician Health Care Providers in Accredited Continuing Medical Education Programs, Introduced by: Paul A. Cox, MD, Specialty Delegate from the Pennsylvania Society of Ophthalmology and Otolaryngology, Author: Paul A. Cox, MD.

43 79-28 (Referred to Reference Committee A), Subject: Elimination of Compulsory Membership Requirement Under Certain Conditions for Osteopaths, Introduced by: Robert S. Sanford, MD, on behalf of the Tioga County Medical Society, Author: Tioga County Medical Society.

52 79-29 (Referred to Reference Committee D), Subject: Repeal of Act 111, Introduced by: Wallace O. Lecher, MD, Secretary, on behalf of the Delaware County Medical Society, Author: Richard J. Morris, MD, on behalf of the Delaware County Medical Society.

49 79-30 (Referred to Reference Committee C), Subject: Hospice Programs, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: Edward D. Viner, MD, on behalf of the Philadelphia County Medical Society.

47 79-31 (Referred to Reference Committee G), Subject: PMS Oppose AMA Direct Billing, Introduced by: Peter A. Theodos, MD, Secretary, on behalf of the Philadelphia County Medical Society, Author: Bernard B. Zamostien, MD, on behalf of the Philadelphia County Medical Society.

44 79-32 (Referred to Reference Committee B), Subject: Health Passport of the Pennsylvania Committee for the International Year of the Child, Introduced by: Samuel S. Faris, MD, Montgomery County Medical Society, Author: Samuel S. Faris, MD.

52 79-33 (Referred to Reference Committee D), Subject: Fluoridation, Introduced by: John J. Maron, MD, Montgomery County Medical Society, Author: Allen S. Weed, MD, Montgomery County Medical Society.

48 79-34 (Referred to Reference Committee C), Subject: Preparation and Availability of "Model Hospital Medical Staff Bylaws" by Appropriate Body of the Pennsylvania Medical Society, Introduced by: F. Gregg Ney, MD, Secretary, Butler County Medical Society, Author: William J. Pherson, MD, Butler County Medical Society.

43 79-35 (Referred to Reference Committee A), Subject: Election to the Judicial Council - Article IX, Section 5 of the Constitution, Introduced by: Arlington A. Nagle, MD, Secretary, Berks County Medical Society, on behalf of the Second Councilor District, Author: Arlington A. Nagle, MD.

45 79-36 (Referred to Reference Committee B), Subject: Abortion, Introduced by: Wallace O. Lecher, MD, Secretary, Delaware County Medical Society, Author: George Isajiw, MD, Delaware County Medical Society.

55 79-37 (Referred to Reference Committee E), Subject: Northeast Pennsylvania Blue Cross, Introduced by: Joseph Demko, MD, Lackawanna County Medical Society, Author: Edward J. Notari, MD, Lackawanna County Medical Society.

48 79-38 (Referred to Reference Committee G), Subject: Financial Reimbursement for Luzerne County Medical Society, Introduced by: Stanley C. Ushinski, MD, President, Luzerne County Medical Society, Author: Luzerne County Medical Society.

52 79-39 (Referred to Reference Committee D), Subject: Moratorium on Medical School Tuition Increases, Introduced by: Dante Landucci, AMSA, University of Pittsburgh, Author: Dante Landucci.

52 79-40 (Referred to Reference Committee D), Subject: Loan Forgiveness to Provide Medical Personnel Redistribution, Introduced by: Dante Landucci, AMSA, University of Pittsburgh, Author: Dante Landucci.

52 79-41 (Referred to Reference Committee D), Subject: Increase in State Loan Amounts to Medical Students, Introduced by: Dante Landucci, AMSA, University of Pittsburgh, Author: Dante Landucci.

55 79-42 (Referred to Reference Committee E), Subject: DPA Medicare Fraud Investigation, Introduced by: Ralph Gaudio, Jr., MD, Secretary, Allegheny County Medical Society, Author: Walter Greissinger, MD.

55 79-43 (Referred to Reference Committee E), Subject: Pennsylvania DPA Reimbursement, Introduced by: Ralph Gaudio, Jr., MD, Secretary, Allegheny County Medical Society, Author: Walter Greissinger, MD.

53 79-44 (Referred to Reference Committee D), Subject: School Treatment of Insect Bite Allergic Children, Introduced by: Ralph Gaudio, MD, Secretary, Allegheny County Medical Society, Author: Gilbert A. Friday, MD.

50 79-45 (Referred to Reference Committee C), Subject: Governor's Conference on HMOs, Introduced by: Irving Williams, III, MD, Secretary, on behalf of the Union County Medical Society, Author: J. Preston Hoyle, MD and Irving Williams, III, MD.

49 79-46 (Referred to Reference Committee C), Subject: HSA Proposed Regulations Inimical to Proper Patient Care, Introduced by: Eugene B. Rex, MD, Interspecialty Committee, Author: Joel Posner, MD, Montgomery County Medical Society.

48 79-47 (Referred to Reference Committee C), Subject: Hospital Staff Presidents' Involvement in Organized Medicine, Introduced by: Norman Goldstein, MD, Chester County Medical Society, Author: Norman Goldstein, MD.

56 79-48 (Referred to Reference Committee E), Subject: Proposed DPW Provider Agreement, Introduced by: Robert Lasher, MD, Author: Robert Lasher, MD.

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**Pennsylvania Emergency Physician** — 200-bed general hospital located in western Pennsylvania university community. New modern Emergency Department. Salary highly competitive. PA license required. Contact: William B. Yeagley, MD, Director of Department of Emergency Services, Indiana Hospital, Indiana, PA 15701.

**Emergency Medicine** — Opportunities available in the suburbs of Buffalo. Immediate openings for career oriented emergency physicians to assume clinical and directorship responsibilities. Fee-for-service with minimum guarantee provided; 30,000 patients seen annually. Professional liability insurance provided. For details, send credentials in complete confidence to Mr. James Thomas, The Churchill Management Group, Inc., 230 Park Avenue, New York, NY 10017, or call (212) 599-0060.

**Psychiatrists** — State positions available at large state hospital in Philadelphia. Direct patient care. Staff supervision. Treatment program planning, opportunities for teaching or research as member of medical school faculty. Good salary and benefits. Required is Pennsylvania State license, board certificate or eligible. To apply, please contact: Gene Abroms, MD, Department of Mental Health Sciences, Hahnemann Medical College & Hospital, 230 N. Broad St., Philadelphia, PA 19102. Equal opportunity employer M/F.

**Instructor** — Diagnostic Radiology - Full time faculty position in the Special Studies area. Position available January 1, 1980. Salary to be discussed. Apply to Jack Edeiken, M.D., Dept. of Radiology, Thomas Jefferson University Hospital, Philadelphia, PA 19107. Equal Opportunity Employer.

**Orthopedic surgeon** — Sports medicine oriented - to head orthopedic department for a newly formed, COMPLETE sports medicine clinic and pain center to be opened in the Mayfair-Northeast section of Philadelphia within six months. Send CV to Department 831, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Pediatrician wanted** — to join two pediatricians for existing vacancy in three man department. This is part of a multi-specialty group of primary care physicians located in Northwest Pennsylvania. This group has been established for 33 years and serves a patient population area of 75,000. There are new office facilities fully equipped and ready for occupancy. Full membership in the corporation will be offered after one year. A very moderate investment is required. We offer an excellent starting salary and a full range of fringe benefits. Contact Robert W. Monroe, MD, Greenville Medical Center, 90 Shenango Street, Greenville, PA 16125, telephone (412) 588-4240.

**Physicians** — Need a change of life style? or a new practice situation?? One of our hundreds of openings nationally is probably the one you are looking for! We confidentially match your geographical, financial, and practice requirements to our many openings and give you detailed information on the practice situations that meet your requirements. There is no charge or obligation to you. Call Durham Medical Search 717-0 Statler Office Building, Buffalo, NY 14202. (716) 852-5911.

**Camp Doctors Needed** — Camp Chen-A-Wanda, fine Pennsylvania Co-ed camp. Season begins June 29, ends August 23. Physicians accepted for two weeks to entire season. Excellent living accommodations for doctor and family. Write: Mr. and Mrs. Morey Baldwin, 8 Claverton Court, Dix Hills, NY 11747. Call Collect (516) 643-5878 (evenings).

**Allergist-Internist** — Salaried position available for board eligible or certified allergist-internist for active private practice. Opportunity for partnership privileges after one year if mutually agreeable. Locality and facilities are ideal with allergy clinic established in large local hospital affiliated with medical school. Send curriculum vitae to: Stephen D. Lockey, III, MD, 60 North West End Avenue, Lancaster, PA 17603.

**Camp physician** — July/August for highly reputable Pennsylvania camp in the Pocono Mountains. State qualifications and family accommodations needed. Contact David Blumstein, 1410 E. 24th St., Brooklyn, NY 11210; Tel: (212) 377-6616.

**Family Practitioners** — to join six physician corporate group practice in Northeastern Pennsylvania. Excellent salary and benefits. Send inquiries to: E.J. Notari, MD, Lackawanna Medical Group, P.C., 493 Morgan Highway, Scranton, PA 18508.

**Physician** — during July and August, 1980 for children's camp located at Beach Lake, PA, accommodates 350 campers, ages 6-16; complete modern Health Center; 2 R.N.'s in attendance; will accept one M.D. for each month; no children accepted who are of camp age. Camp opens June 27 and closes August 22. Private room and facilities. Write to Trail's End Camp, c/o Beach Lake, Inc., 215 Adams Street, Brooklyn, NY 11201, and include your phone number.

**Emergency Room Physician** — Six year old, 212 bed community hospital, Western Pennsylvania. Full-time position available. Physician participates in all hospital benefit programs including liability insurance. In addition to 3 weeks paid vacation, an additional 5 days is made available for continuing education in Emergency Medicine each year. Write or call: F.O. Robertson, MD, Director, Emergency Medical Services, Armstrong County Memorial Hospital, Kittanning, PA 16201. (412) 543-8404 Collect.

**Physicians** — for clients in Pennsylvania, Massachusetts, and Michigan. Specialists in family practice, obstetrics/gynecology, pediatrics, neurosurgery, d. rad., ENT, psychiatry, indust. and phys. medicine. Fee Paid. Call E.J. Mowry (215) 348-8700.

**House Staff Physician** — Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $40,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Executive Director, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

**NEEMA Emergency Medical**—a professional association—Emergency medicine positions available with emergency physician groups throughout Pennsylvania, N.Y., N.J., Michigan, and Southeastern U.S., including all suburban, rural, and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to NEEMA Emergency Medical, Suite 400, 399 Market St., Philadelphia, PA 19106, or telephone (215) 925-3511.

**Staff Psychiatrists** — Full or Part Time positions immediately available. Our hospital is looking for psychiatrists with fresh ideas and strong convictions on public sector mental health care. We are located in pleasant, residential Northeast Philadelphia and can offer the area's unparalleled opportunities for professional growth and development. Good salary and benefits. Requirements are PA State license and board certification or eligibility. Contact, in strict confidence: Franklyn R. Clarke, M.D., 14000 Roosevelt Blvd., Phila., PA 19114, (215) 671-4101.

**OB/GYN Specialist** — Hospital located in recreational heart-lands of Northwestern Pennsylvania has immediate need for physicians in order to continue and expand its health care delivery to the people in its service area. It is our concern to attract someone who is concerned with both the quality of medical practice and the quality of life both his self and family would want to lead. Contact Administrator, B.J. Carotenuto, Port Allegany Community Hospital, Port Allegany, PA collect 1-814-642-2541.

**Emergency Physicians**—A multi-hospital group of emergency physicians seeks members for full-time positions at major hospital emergency departments in Philadelphia and other areas of Pennsylvania. In addition to full-time emergency physicians, a physician director is sought for each emergency department. The group encourages professional and administrative autonomy in its member physicians. Financial arrangements are fee-for-service with minimum guarantee. Emergency-oriented educational programs for physicians are maintained by the group at no charge to its members. Compensation ranges from $40,000 to $60,000 per year for 48 hours per week. Write: Department 650, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, Pa. 17043.

**Pennsylvania emergency physician system** — Needs several fulltime emergency physicians, for Western Pennsylvania area emergency departments. Independent contractor arrangements. Eligible for corporate membership within two years. The system is on a "fee-for-service" basis. Contact: (412) 228-3400 for interview appointment.

**Family practice southeast** — Private practice opportunity group or solo in medium size city with new 150 bed hospital. Present medical staff of 24 with three FPs age 64. Attractive office space and complete financial assistance package. Family oriented stable community. Send curriculum vitae in confidence to Mr. William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Georgia 30338.

**Otorhinolaryngologist** — Position available, and demand for board certified or eligible, 89 bed hospital in Western Pennsylvania. Excellent growth potential for practice in community and surrounding area. Send curriculum vitae or call Punxsutawney Area Hospital, Punxsutawney, PA 15767; (814) 938-4500, Joseph O. Yesh, President.

**Emergency Physicians**—Suburban Philadelphia hospitals. FFS with minimum guarantee, 42 hours per week average. Experience preferred but will consider all applicants. Contact Teddy Trout (215) 242-4707 for further details or send CV to P.O. Box 192, Flourtown, PA 19031.

**Psychiatrist** — board-certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact George E. Gittens, MD, Acting Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411, (717) 586-2011.

**Orthopedic Surgeon Wanted**—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

**Director, Radiology Department** — Immediate opening, 6 year old, 212 bed community hospital, Western Pennsylvania, 50 miles from Pittsburgh. Department provides nuclear medicine, angiography, ultrasonography, cobalt teletherapy, mammography, cinefluoroscopy, and new head and full body CT Scanner. Seeking Board Certified individual with 5 to 8 years clinical experience, to include medico-administrative experience in active Radiology Department. Departmental growth will ultimately require 2 associates. Fee for service considered. Location affords best of country living with easy access to cultural, academic, and recreational opportunities of Pittsburgh. Reply to Robert L. Engel, Administrator, Armstrong County Memorial Hospital, Kittanning, PA 16201 with letter of interest and resume.

**Camp Physician and Nurses** — July/August for two, four, or eight week period. N.E. Pennsylvania, family accommodations, private lake, tennis, two RNs. Camp Wayne, 12 Allevard St., Lido Beach, NY 11561, (516) 889-3217.

**Emergency Medicine Opportunity** — to be awarded to career oriented emergency physician at 180-bed hospital near Pittsburgh; 45,000 population community. Successful candidate will receive excellent annual guarantee and paid professional liability insurance. For further details, submit credentials to Mr. Joe Woddail, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free 1-800-325-3982.

## FOR RENT

**Caribbean Condo** — Deluxe 3 bedroom Coakley Bay Condo located on St. Croix. Available for weekly or longer rentals. Save up to 50% of hotel rates. Contact A. Apter, (215) 643-5128 evenings.

**Attention** — Orthopedic surgeons, GPs, and internists. Sumed Enterprises, Inc. has prime office space available in medical office buildings close to the Northwest Medical Center in the 1960 - I 45 Houston area, the fastest growing city in America. For further information about this booming community, call or write: Sumed Enterprises, Inc., 830 F.M. 1960 West, Suite 12, Houston, Texas 77090, Attention M. Nierman. Telephone (713) 893-1024.

**Office Space** — New professional building, suburban Pittsburgh, Bethel Park, PA. Ideal for pediatrician or other physician. Approximately 3,000 square feet available immediately. Call (412) 833-6188.

## FOR SALE

**Bucks County professional center** — Modern, well-established medical practice and excellent hospital privileges also available. Very high net income. Total package, including Real Estate: $110,000. Excellent financing available. E.C. McGinley, Inc., Professional Practice Services, 151 Windsor Rd., Yardley, PA 19067. (215) 493-4346.

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**Physician's assistants** — Become a warrant officer in the Pennsylvania Army National Guard in a unit near your home. Serve one weekend a month and a fifteen (15) day annual training period each year. You will be eligible for continuing professional education, monthly pay, and a substantial non-contributory retirement plan. Enjoy the personal satisfaction of doing an important job for your state and nation. For further information contact Major Eugene P. Klynoot, Department of Military Affairs, Pennsylvania Army National Guard, Annville, PA 17003. Telephone (717) 783-3430.

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Address inquiries to office of Council Secretary,
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Term expires 1981

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PENNSYLVANIA MEDICINE
Office of Publication, 20 Erford Rd., Lemoyne 17043
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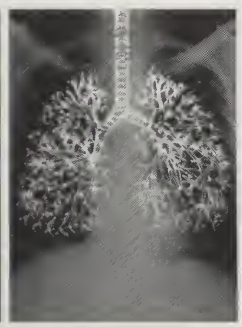
***UPPER RESPIRATORY***

acute otitis media in children



***LOWER RESPIRATORY***

acute exacerbations of chronic bronchitis in adults —documented *Pneumocystis carinii* pneumonitis

***GENITO-URINARY***

recurrent urinary tract infections

***GASTRO-INTESTINAL***

shigellosis

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

**For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.**

**For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.**

**For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.**

**Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.**

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage: Not recommended for infants less than two months of age.**

*URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:*

*Adults:* Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

*Children:* Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

*For patients with renal impairment:* Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

*ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:*

*Usual adult dosage:* 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

*PNEUMOCYSTIS CARINII PNEUMONITIS:*

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; cherry flavored—bottles of 16 oz (1 pint). *Suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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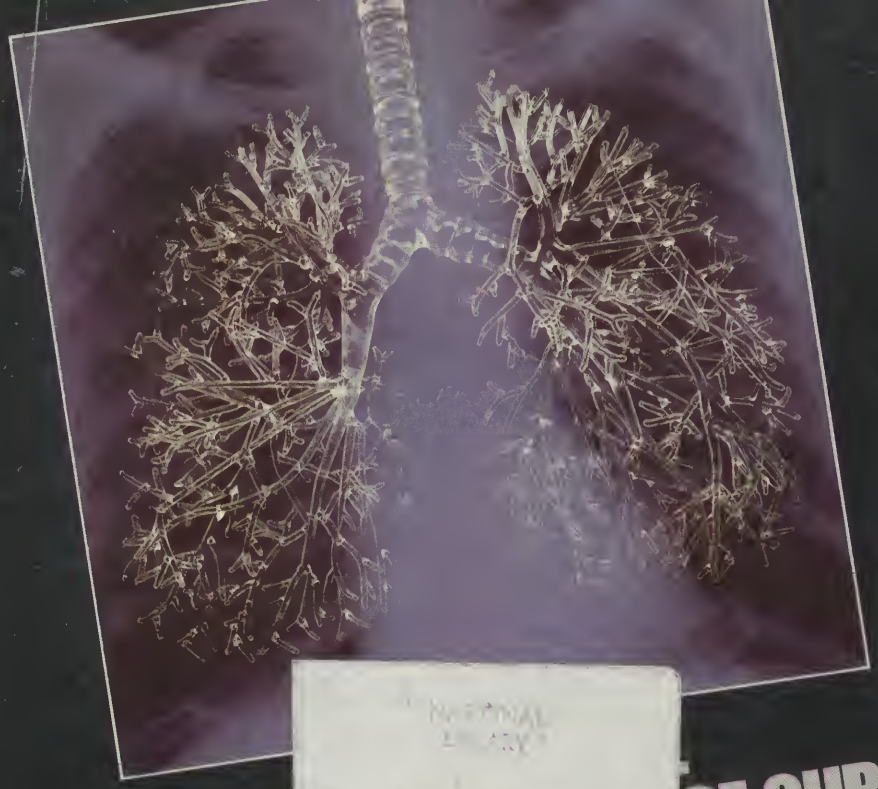

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# ACUTE EXA OF CHRONIC BRONCHITIS

# BACTRIM™ DS

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

**91% OVERALL SUCCESS RATE 7 DAYS POSTTHERAPY IN CONTROLLED MULTICENTER STUDIES INVOLVING H. INFLUENZAE AND S. PNEUMONIAE†**

LOW INCIDENCE OF DIARRHEA AND SUPERINFECTION. GASTROINTESTINAL AND DERMATOLOGICAL REACTIONS WERE THE MOST FREQUENT SIDE EFFECTS IN THE STUDY.

MAY BE USED IN PATIENTS ALLERGIC TO PENICILLINS AND CEPHALOSPORINS.

CONVENIENT B.I.D. DOSAGE ENCOURAGES COMPLIANCE.

BACTRIM IS INDICATED IN ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS WHEN IN THE PHYSICIAN'S JUDGMENT IT OFFERS AN ADVANTAGE OVER A SINGLE ANTIMICROBIAL AGENT.

*due to susceptible *H. influenzae* or *S. pneumoniae*

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Please see preceding page for a summary of product information.

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WJ
PE385P

# Pennsylvania Medicine

Vol. 83, No. 2 FEBRUARY 1980

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# In acute exacerbations* of chronic BRONCHITIS

## IN ADULTS

* due to susceptible *H. influenzae* or *S. pneumoniae*

# 91% overall success rate 7 days post therapy in controlled multicenter studies involving *H. influenzae* & *S. pneumoniae*†

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**85%**
Causative organism eliminated at end of 14-day treatment (51 of 60 patients)

**91%**
Causative organism eliminated at 7-day follow-up (50 of 55 patients; 5 patients did not return for follow-up)

- ☐ Low incidence of diarrhea and bronchial superinfection.
- ☐ Gastrointestinal and dermatological reactions were the most frequent side effects in the study.
- ☐ May be used in patients allergic to penicillins and cephalosporins.
- ☐ Convenient b.i.d. dosage encourages compliance.
- ☐ During therapy, maintain adequate fluid intake. Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma.

**Bactrim is indicated in acute exacerbations of chronic bronchitis in adults when in the physician's judgment it offers an advantage over a single antimicrobial agent.**

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# BACTRIM™ DS

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Please see next page for summary of product information.

# BACTRIM™

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(trimethoprim and sulfamethoxazole)

## *A MAJOR ANTIMICROBIAL WITH MULTI-SYSTEM USEFULNESS*

The clinical usefulness of Bactrim continues to grow. Now Bactrim is useful for all of the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

***UPPER RESPIRATORY***

acute otitis media in children

***LOWER RESPIRATORY***

acute exacerbations of chronic bronchitis in adults —documented *Pneumocystis carinii* pneumonitis

***GENITO-URINARY***

recurrent urinary tract infections

***GASTRO-INTESTINAL***

shigellosis

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# medigram

**OFFICERS' CONFERENCE TO TOUCH MANY BASES**

AMA President Hoyt D. Gardner, MD, and two of the Thornburgh administration's cabinet heads will be among the speakers at the Society's 1980 Officers' Conference April 23-24 at the Penn Harris Motor Inn, Camp Hill. Secretary of Health H. Arnold Muller, MD, and Welfare Secretary Helen O'Bannon will represent the administration. The program will include a panel discussion on hospital medical staff bylaws, a consumer's view of the delivery of health care, and a forecast of the 1980 state and national elections.

**PMS PRESIDENT APPOINTS NEW COMMITTEE MEMBERS**

Matthew Marshall, Jr., MD, PMS president, has appointed six physicians to the Advisory Committee on Professionalism. They are Drs. G. Winfield Yarnall, James A. Collins, Jr., John L. Kelly, Frank V. Maida, James R. Regan, and John Y. Templeton, III. Dr. Yarnall, PMS secretary, is chairman of the new standing committee of the Society.

**PMS EXECUTIVE COMMITTEE ATTENDS LEADERS MEETING**

The Executive Committee of the Society's Board of Trustees will attend the AMA Leadership Conference February 21-24 at the Chicago Marriott Hotel. General sessions and seminars on current issues will include an address by President Jimmy Carter or his designate. Executive Committee members are Drs. David J. Keck, David W. Clare, Kenneth L. Cooper, Leroy A. Gehris, Raymond C. Grandon, John B. Lovette, and Matthew Marshall, Jr.

**DR. LEVIS RE-ELECTED AMPAC BOARD CHAIRMAN**

Michael P. Levis, MD, of Pittsburgh, has been re-elected chairman of the Board of Directors of the American Medical Political Action Committee. Dr. Levis is past president of the Allegheny County Medical Society and is currently a Pennsylvania delegate to the AMA. He is a member of the PMS House of Delegates and has served the State Society in a number of capacities.

**MEDICAL BOARD FORMS PA ADVISORY GROUP**

The State Board of Medical Education and Licensure has appointed an advisory group on physician assistants (PAs). One of the group's first tasks will be to propose regulations covering the prescribing and dispensing of medications by PAs. Physicians appointed to the six-member group are Rugh A. Henderson, MD, Hershey; John H. Moyer, III, MD, Johnstown; and Joseph M. Sienkiewicz, MD, Mount Carmel. Serving with them will be three physician assistants, representing some 600 in Pennsylvania.

**MEDICAL FEES 3% BELOW CONSUMER PRICE INDEX**

The success of the campaign of the AMA and the State Society for voluntary fee restraint is established. The increase in medical fees, according to latest statistics, is a full 3 percent below the increase in the Consumer Price Index. AMA Executive Vice President James Sammons, MD, called the restraint a "massive accomplishment" by American physicians. He said that physicians have clearly demonstrated their intention to make the voluntary effort work.

PMSLIC BOARD ELECTS NEW VICE PRESIDENT

The Board of Directors of the Pennsylvania Medical Society Liability Insurance Company elected Ronald M. Bachman, of New Cumberland, vice president on January 9. Along with expanded administrative duties, Bachman will continue as director of marketing. He joined the PMSLIC staff in January 1979, after having served PMS as director of economic affairs. The Society-owned company insures some 5,300 PMS members.

ADMINISTRATION NAMES MENTAL HEALTH DEPUTY

H. Scott Nelson, MD, a psychiatrist and a commissioned officer in the U.S. Public Health Service, assumed his duties as deputy secretary of welfare and commissioner of mental health in January. Although he has long maintained a farm in Fulton County, he comes to Pennsylvania from New Mexico, where he served as state director of behavioral health services. He has had experience at both state and federal government levels, is a member of a number of professional societies, and is the published author of over 30 articles. Dr. Nelson is detailed to Pennsylvania under an agreement between the Commonwealth and the U.S. Department of Health, Education, and Welfare.

COUNCIL ON MEMBER SERVICES SENDS "OVER SIXTY" SURVEY

The Society's Council on Member Services is conducting a random sample of PMS members who are at least 60 years old. Developed by the Council's Advisory Committee on Second Careers, the survey is intended to determine the needs of physicians who are nearing retirement or considering alternative medical practice. Over 25 percent of the membership has reached age 60.

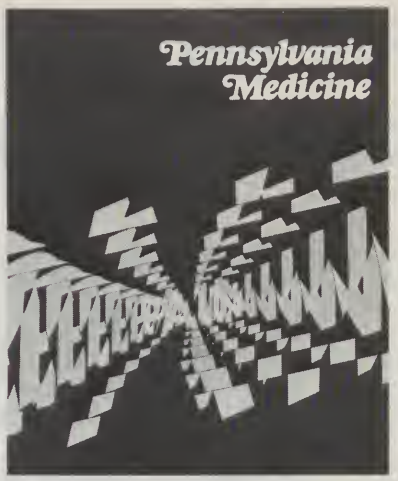
DHEW LAUNCHES NATIONAL SECOND OPINION PROMOTION

The Department of Health, Education, and Welfare in January launched a promotion urging the public to seek a second opinion before having elective surgery. Using television, radio, brochures, posters, and a toll-free hotline, the campaign also encourages patients to discuss frankly with their physicians how to get a second opinion on the necessity of surgery. The Health Care Financing Administration is conducting the promotion which is directed at the general public, but especially the 47 million medicare and medicaid recipients. In announcing the campaign, HEW said that the surgery rate for persons aged 65 and older increased 44 percent between 1966 and 1976.

PA FORUM ON FAMILIES ANNOUNCES LOCATIONS

Dates and locations of four statewide meetings in preparation for the White House Conference on Families have been announced by Welfare Secretary Helen O'Bannon. People interested in attending one of the statewide forums or the White House Conference in Baltimore, MD, this summer may contact the Pennsylvania Forum on Families, 204 Weaver Bldg., University Park, PA 16802. The four statewide meetings are: February 19, Sterling Hotel, Wilkes-Barre; February 21, 402 Keller Bldg., PSU, University Park; February 26, Main Branch, Free Library, Logan Square, Philadelphia; and February 28, YWCA, Fourth and Wood Sts., Pittsburgh.

Pennsylvania Medicine

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**PENNSYLVANIA MEDICINE**
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

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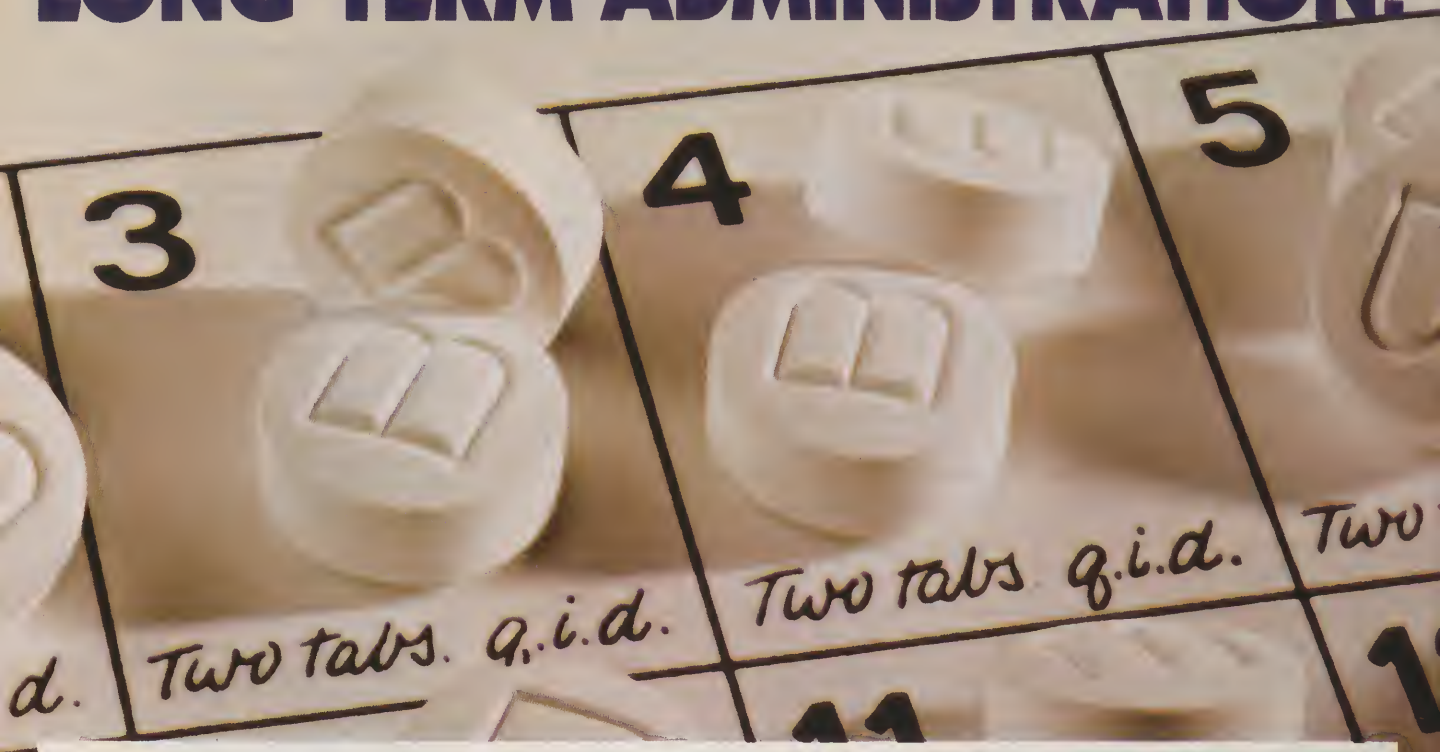

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Subjects in these controlled trials, which utilized a crossover design, were given Bufferin and Bayer® Aspirin for two weeks each in a balanced order of administration. The cumulative gastric tolerance superiority of Bufferin over plain aspirin was significant ($P = <.01$) from day one and persisting through each day of the study. This superiority for an extended period could be of particular importance to patients on repeat-dosage schedules.

For full aspirin benefits, together with excellent gastric tolerance, Bufferin should be your brand of choice. If you are prescribing a regimented daily dose of aspirin, prescribe Bufferin—the repeat-dosage aspirin—instead.

## BUFFERIN: The Repeat-Dosage Aspirin.

For complimentary samples of Bufferin and Arthritis Strength Bufferin, please write: Bufferin, P.O. Box 65, Elizabeth, New Jersey 07207.
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# editorial

## Radiation—as it increases so does our responsibility

The Three Mile Island nuclear accident has heightened awareness of radiation and at the same time awakened in people a fear that can best be described as unreasoning.

As physicians know, radiation cannot be sensed. One cannot see, feel, smell, hear, or taste it. But radiation causes cancer, the most dreaded of diseases. It is thought to cause genetic abnormalities. Fetuses and young children, it is claimed, are at the greatest risk from radiation.

Livy (*Histories*) said, "We fear things in proportion to our ignorance of them. Most Americans have little exposure to information to allay their fears of radiation. Most people think about radiation in terms of its most commonly stated use, the atomic bomb.

Americans rely on the news media for information regarding radiation. They depend on responsible reporting of current events and scientific newswriters. Too often, news consists of scare information—statistics and numbers without adequate explanation.

Reporting during the height of the TMI crisis deserves commendation. The major sources responded to the public's demands by relaying news with dispatch and attempting to define scientific terms for general consumption. Indeed, residents of Central Pennsylvania did not stray far from their radios.

A fact deserving more emphasis is that radiation comes from sources other than malfunctioning nuclear plants. There is natural radiation which comes from the sky (cosmic) and from the earth's crust (decaying isotopes). Building materials, airplane flight, atomic testing, and greater elevation above sea level all increase natural background exposure.

Furthermore, a portion of the population is exposed occupationally to larger than background doses. These occupations include uranium miners, nuclear physicists, radiologists, and radium clock dial painters. An estimated half of the radiation received per year is a result of medical and dental x-ray procedures.

The risks of radiation especially at low doses is a controversial subject among scientists. Scientists do know the biological effects of large doses of radiation delivered in short periods of time. Generally they agree to an observed progression based upon the magnitude of the dose received. But knowledge of low dose effect is insufficient to reach any conclusions. The Central Pennsylvania population may well be the base for a large scale study of long term, low dose effects of radiation.

Extrapolation from high dose and its effect to zero dose, zero effect, would seem to indicate that even small doses would have some detrimental effect. The extent to which low doses are responsible for induction of cancer or genetic damage remains to be seen. It is nearly impossible to separate the effect of low doses from other known risk factors for cancer, such as smoking.

Another consideration is the composition of radiation, described as gamma and proton/neutron percentages. Studies on the survivors of the Hiroshima and Nagasaki bombings indicate more radiation damage in the Hiroshima group. The more extensive damage to the Hiroshima group demonstrates the long-range effect of proton/neutron radiation. The Hiroshima bomb contained as high as one-fourth neutron radiation; the Nagasaki bomb was composed largely of gamma radiation.

The increases in radiation exposure since the atom was harnessed for human use promise to continue. As we rely more on nuclear power and advanced radiologic diagnostic and treatment procedures, the responsibility of the medical community will increase over a broad spectrum.

Our primary concern is that the radiologic procedures we order have appropriate medical indications. X-rays of all types are invaluable diagnostic aids but ought not to be ordered as substitutes for careful medical appraisal. Radiologic equipment should be monitored to insure proper functioning and no radiation leakage.

Physicians should be aware of the problems in treating radiation casualties and should be prepared to deal with these. TMI has proved that such occurrences are not beyond the realm of possibility.

Specially trained physicians ought to be included in planning nuclear facilities. Reactor sites should be chosen so as to minimize biological and ecological harm.

Physicians also should be involved in disaster prevention and in mass evacuation planning, not only for hospitalized patients but for entire communities. The TMI accident highlighted our present inadequacies in this area. The importance of a smooth workable evacuation plan cannot be overemphasized.

Far too little is understood about radiation to accept any unnecessary risks. If "knowledge is the antidote to fear" (Merson, *Courage*) there is still a great deal to learn about the effects of atomic energy. For the present, judicious use with stringent cautionary measures should be exercised.

"If a little knowledge is dangerous, where is the man who has so much as to be out of danger?" (T. H. Huxley, *Elemental Instruction in Physiology* ) I know of no such person. Do you?

David A. Smith, MD
Medical Editor

### BIBLIOGRAPHY


1. **Upton, Arthur C.:** Interivew: Low-level radiation. *CA - A Cancer Journal for Clinicians 29:*306-315, 1979.
2. **Finch, Stuart C.:** The study of atomic bomb survivors in Japan. *American Journal of Medicine 66:*899-901, 1979.
3. **Culliton, Barbara J.:** Low-dose radiation. *British Medical Journal 1:*1545-1546, 1979.
4. Natural Background Radiation in the United States. *NCRP Report No. 45.* National Council on Radiation Protection and Measurements. Nov 15, 1975.

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# newsfronts

## AMA faces financial problems, must increase revenue

Pennsylvania's delegates to the AMA interim meeting in Hawaii December 2-5 heard leaders warn that financial problems lie just over the horizon.

"While the 1980 budget will end $5 million in the black," said John B. Lovette, MD, Pennsylvania Delegation chairman, "the AMA must increase revenue to meet the 1981 budget. At the annual meeting next July, delegates must vote either to curtail services or raise dues (currently $250 annually)."

The more attractive but also more difficult alternative is to increase membership. Officials pointed out that it now takes a minimum net increase of 20,000 members each year simply to maintain current levels of programs and services. Currently the percentage of AMA members against the U.S. physician population continues to decline. While overall AMA membership is up, particularly among students and residents, the number of new full dues paying members is not sufficient to assure financial stability.

Pennsylvania is one of less than half of all state societies to have an active membership recruitment program. Dr. Lovette, immediate past president of the State Society, made AMA member recruitment one of his presidential priorities. The day to day work on recruitment is carried out by the Council on Member Services chaired by William A. Shaver, MD, Lebanon.

Dr. Shaver said, "We ran a vigorous AMA recruiting campaign in 1979 including doctor to doctor appeals and several direct mail letters from Dr. Lovette. We stopped a losing streak and actually added several hundred new AMA members from Pennsylvania. This drive is continuing in 1980."

PMS President Matthew Marshall, Jr., MD, Pittsburgh, also an AMA Delegate, has called on PMS to reconsider unified membership. When the PMS House meets this fall in Philadelphia, delegates will consider amendments to the PMS Constitution

John B. Lovette, MD, chairman of the Pennsylvania Delegation, is in the foreground, left. Drs. Tyson, Marshall, Donaldson, and Grandon also are shown.

Drs. Alexander, Fetterman, Rowland, Moyers, and Levis are attentive at the opening session of the House of Delegates.

Michael P. Levis, MD, Pittsburgh, chairman of the American Medical Political Action Committee, reports.

William Y. Rial, MD, Swarthmore, speaker of the AMA House of Delegates, conducts business.

# Dr. Crawford heads Dauphin County Society

Donald G. Crawford, MD, a board certified family practitioner, is the new president of the Dauphin County Medical Society. He was installed at the society's 114th annual meeting December 13, 1979 and succeeds Lewis T. Patterson, MD.

A 1963 graduate of Hahnemann Medical College, Dr. Crawford served his internship at Harrisburg Hospital. Currently, he is a medical staff physician with the family medicine departments at Harrisburg Hospital and Polyclinic Medical Center.

Throughout 15 years membership in the county society, Dr. Crawford has assumed leadership roles. He is chairman of the Council on Interprofessional and Public Relations, member of the board of governors, finance committee, and delegate to the state society.

Dr. Crawford also participates at the state level as chairman of the Members Services Committee of the PMS Council on Professional Relations and Services. He is on the board of directors of the Credit Union and chairman of the Credit Committee.

Dauphin County Medical Society officers installed with Dr. Crawford are Richard J. Patterson, MD, president elect; John Burnside, MD, first vice president; Marilyn Mahon, MD, second vice president; and David A. Smith, MD, secretary treasurer.

**Lewis T. Patterson, MD, immediate past president of Dauphin County Medical Society, congratulates Donald G. Crawford, MD, center, 114th president. Richard J. Patterson, MD, right, is president elect.**

## AMA faces financial problems

and Bylaws establishing unified membership.

In contrast to a year earlier when national health insurance was a major issue, this year's house reaffirmed the four principles agreed to previously and commended the AMA Board for its handling of NHI.

The four AMA principles are: minimum standards in all health insurance policies sold in the U.S., including appropriate deductibles and co-insurance; a simple system of uniform benefits provided by federal, state, and local government to individuals who through no fault of their own are not able to provide for their own medical care; a nationwide program by the private insurance industry (and government, if necessary) to make available catastrophic insurance; and the administration of health insurance at the state level with national standardization through federal guidelines.

Delegates representing PMS at the interim meeting were Drs. R. William Alexander, Reading; James B. Donaldson, Philadelphia Henry H. Fetterman, Allentown; Raymond C. Grandon, Harrisburg; Michael P. Levis, Pittsburgh; John B. Lovette, Johnstown; Matthew Marshall, Jr., Pittsburgh; Robert N. Moyers, Meadville; William Y. Rial, Swarthmore; and R. Robert Tyson, Philadelphia.

Alternates attending from Pennsylvania were Drs. Donald C. Brown, Irwin; Robert J. Carroll, Pittsburgh; Betty L. Cottle, Hollidaysburg; Joseph N. Demko, Scranton; George R. Fisher, Philadelphia; Charles A. Heisterkamp, III, Lancaster; David J. Keck, Fairview; and Irving Williams, III, Lewisburg.

Pennsylvania also was represented by three medical students and six resident physicians. Including specialty society delegates and present and past AMA officials from the Commonwealth, Pennsylvanians present numbered 35.

**H. Arnold Muller, MD, of Hershey, was sworn in as Pennsylvania's secretary of Health in December. Shown above, he made remarks following the ceremony.**

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Large societies install

# New officers take helm in Allegheny, Philadelphia

## Allegheny County

Harold E. Swensen, MD, was installed as the 115th president of the Allegheny County Medical Society on January 12, 1980.

Dr. Swensen, an orthopedic surgeon, has been a Society member since 1964 and has served on the board of directors since 1976.

An alumnus of the University of Pittsburgh School of Medicine, Dr. Swensen interned at Allegheny General Hospital. He served his residency in general surgery at the Veterans Administration Hospital in Oakland.

He is affiliated with Children's, Presbyterian-University and The Western Pennsylvania hospitals and is a clinical associate professor of orthopedic surgery at Pitt's medical school.

Also installed at the annual dinner were Drs. James R. Dornenburg, president elect; Abraham J. Twerski, first vice president; Ralph Gaudio, Jr., secretary; and H. Lee Dameshek, treasurer.

Allegheny County honored two other physicians, Robert M. Laughlin, MD, and Samuel J. Klatman, MD. Dr. Laughlin received the Frederick M. Jacob Physician Merit Award for outstanding service; Dr. Klatman was recognized for almost a half century of dedication to general practice with the Nathaniel Bedford Award.

DR. SWENSON

DR. KRASNOFF

## Philadelphia County

Philadelphia County Medical Society installed Sidney O. Krasnoff, MD as 119th president on January 16, 1980. Dr. Krasnoff succeeds Robert S. Pressman, MD.

Dr. Krasnoff received his medical degree from the University of Pennsylvania in 1942. He currently serves as senior attending physician in medicine at Albert Einstein Medical Center, Northern Division, and clinical professor of medicine at Temple University.

Edward J. Resnick, MD was re-elected vice president. Dr. Resnick is professor of orthopedic surgery at Temple University Hospital and director of the Pain Control Center.

Also elected were Paul J. Poinsard, MD, president-elect; Peter A. Theodos, MD, secretary; and George Ross Fisher, III, MD, treasurer.

## Heart association plans scientific session

Diagnosis and treatment of syncope will be the subject of scientific sessions sponsored by the American Heart Association's Pennsylvania Affiliate, April 17-18, at Hotel Hershey, Hershey.

The cardiology division of Hershey Medical Center and the Council on Clinical Cardiology of the American Heart Association join in the sponsoring.

A clinical presentation on syncope will open the program. Sessions on electrophysiological studies in the evaluation of syncope, choice of pacemakers for adults and children, and differential diagnosis from a neurological standpoint will follow.

The second day's session will begin with cerebral vascular disease, its diagnosis, angiographic considerations, and surgical treatment. In the afternoon, specialists will discuss antihypertensive agents and echocardiographic self-assessment.

The course, AMA approved for 12 hours credit Category I, is also acceptable for 12 prescribed hours by AAFP and approved by ACGP (Osteopathic) for 12 Class II hours.

For program and registration information, contact your local chapter or the American Heart Association, Pennsylvania Affiliate, P.O. Box 2435, Harrisburg, PA 17105.

## Glaucoma conference at Wills Hospital

The Pennsylvania Academy of Ophthalmology and Otolaryngology and Jefferson Medical College will cosponsor a glaucoma conference, June 6-7, 1980, at the new Wills Eye Hospital.

Entitled "Glaucoma: Up-to-date", the conference is presented by the Glaucoma Service of the Wills Eye Hospital. Members of the Glaucoma Service staff will serve as faculty members.

For further information contact Dr. Kenneth Benjamin, c/o Glaucoma Service, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, PA 19130.

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# U.S. Supreme Court rules on statute of limitations

**Fred Speaker, Esq.**

The Supreme Court of the United States has ruled that a statute of limitations in a medical malpractice case should be strictly construed.[1] The Court decided on November 28, 1979, that the two year period began to run when the patient learned of his injury, not when he discovered that the injury was caused by negligence.

Because the case was brought under the Federal Tort Claims Act,[2] the Supreme Court decision does not have universal application in medical malpractice cases. Nonetheless, it should be of significant persuasion against attempts to broaden the application of state statutes of limitations.

The *Kubrick* case, under the decision of the Federal District Court[3] and the Court of Appeals,[4] had ruled that even though a plaintiff had been aware of his injury and the defendant's responsibility, the statute of limitations did not begin to run where he was able to show that "in the exercise of due diligence he did not know, nor should he have known, facts which would have alerted a reasonable person to the possibility that the treatment was improper."[5]

In a previous issue of PENNSYLVANIA MEDICINE,[6] we explained the *Kubrick* case which involved a patient treated with neomycin for osteomyelitis at a VA hospital. Treated in 1968, the patient soon noticed a hearing loss which progressively worsened even though he consulted five physicians.

In 1969 one of the physicians said that the use of neomycin was a likely cause of the patient's condition; he did not say its use constituted malpractice. Two years later, another specialist said the condition was caused by malpractice. The patient sued within two years thereafter.

Since the claim was against the federal government, the applicable statute of limitations provides:

> A tort claim against the United States shall be forever barred unless it is presented in writing to the appropriate Federal agency within two years after such claim accrues. . . .[7]

The determinative issue of the *Kubrick* case was the timetable of accrual. Did the claim "accrue" when the patient first learned that he was a victim of malpractice (if so he would win), or did it accrue when he first learned of the cause of his illness (if so he would lose)?

Mr. Justice White, speaking for the majority on the general purposes of statutes of limitations, said:

> . . . although affording plaintiffs what the legislature deems a reasonable time to present their claims, they protect defendants and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise. . . . We should regard the plea of limitations as a "meritorious defense, in itself serving a public interest." *Guaranty Trust Co. v. United States,* 304 U.S. 126, 136 (1938).[8]

The majority opinion continued:

> We thus cannot hold that Congress intended that "accrual" of a claim must await awareness by the plaintiff that his injury was negligently inflicted. A plaintiff such as Kubrick, armed with the facts about the harm done to him, can protect himself by seeking advice in the medical and legal community. To excuse him from promptly doing so by postponing the accrual of his claim would undermine the purpose of the limitations statute, which is to require the reasonably diligent presentation of tort claims against the Government.[9]

The applicable statute of limitations in Pennsylvania is at least similar to the provisions of the federal statute construed in the *Kubrick* case. The present statute states:

> The following actions and proceedings must be commenced within two years: . . . An action to recover damages for injuries to the person or for the death of an individual caused by the wrongful act or neglect or unlawful violence or negligence of another.[10]

Although this provision has yet to be construed by an appellate court in a medical malpractice case, its predecessor has been examined. In the case of *Ayers v. Morgan,*[11] The Su-

## Court disallows pain, anguish claim

An identical twin who was not operated on and did not witness the surgical procedure performed on her identical twin sister has no claim for great pain or mental anguish suffered because of negligent surgery on her twin. The Pennsylvania Commonwealth Court in November decided the case.[1]

The Court made it clear that:

> . . . the law in Pennsylvania requires the personal observation of the event. No exception is made for an identical twin who alleges she is present at all times with her twin sister, albeit she is in a different physical location. The traumatic impact from viewing the negligent injury of one's close relative is wholly absent in this case.[2]

The Court relied on a recent decision[3] of the Pennsylvania Supreme Court which stated the prerequisites to a successful suit for psychic damages—for seeing negligently caused injury to another. The three essentials include (1) a serious, direct shock, (2) to a close relative (3) who is near the accident.

---

1./ *Hoffner, et al. v. Hodge, et al.*——Pa. Commw. Ct.——(No. 2907 C.D. 1978, Nov. 14, 1979).

2./ *Id.* at pp. 3-4.

3./ *Sinn v. Burd,* 404 A.2d 672 (Pa. 1979).

preme Court of Pennsylvania considered the meaning of the statutory phrase, "brought within two years from the time when the injury was done."[12]

The *Ayers* case concerned a patient who was operated on for a marginal jejunal ulcer. Thereafter, he experienced pains for the next several years. Almost nine years later he returned for tests to the hospital, where they found that a sponge had been left in his body during the previous operation.

The Court, holding that the statute of limitations started to run when the patient discovered, or should have discovered the cause of his affliction, ruled that the patient had two years to file after he first learned what was causing his pains. The Court stated that "the injury is done when the act heralding a possible tort inflicts a damage which is physically objective and ascertainable."[13]

The *Ayers* case did not consider a situation in which the cause of the illness is discovered but the possibility of malpractice was not known. Pennsylvania courts, since the *Ayers* case, have not considered this issue; but federal courts have indicated their use of a broader view of the Pennsylvania statute.[14] The decision of the United States Supreme Court may well discourage this expansionist trend.

1./ *United States v. Kubrick*, 48 U.S.L.W. 4030 (1979).
2./ 28 U.S.C. §1346.
3./ 435 F.Supp. 166 (E.D.Pa. 1977).
4./ 581 F.2d 1093 (3rd Cir. 1978).
5. *Id.* at 1097.
6./ Pp. 12-3 (June, 1978).
7./ 28 U.S.C. §2401(b).
8./ *United States v. Kubrick, supra* at 4032.
9./ *Id.* at 4033.
10./ 42 Pa.C.S. §5524(2).
11./ 397 Pa. 282 (1959).
12./ 12 P.S.§34 (repealed effective June 27, 1978).
13./ *Ayers v. Morgan*, 397 Pa. 282, 290 (1959).
14./ See PENNSYLVANIA MEDICINE, p. 25 (December 1978).

## Ruling on no-fault law affects chiropractic

Chiropractic services are not "medical services" under Pennsylvania's No-Fault Motor Vehicle Insurance Act.

The Superior Court of Pennsylvania held so in an opinion filed December 14, 1979. The entire opinion is reproduced below.

> Appellant contends that chiropractic services should qualify as "medical services" for purposes of meeting the threshhold requirements of section 301 (a) (5) (b) of the No-fault Motor Vehicle Insurance Act, Act of July 19, 1974, P.L. 489, No. 176, Art. III, sec. 301 (40 P.S. §1009.301). In the case of *Babcock v. Tippett,* Pa. Superior Ct., 394 A.2d 607 (1978), we held that *chiropractic services do not so qualify.*
>
> Accordingly, the order of the court of common pleas is affirmed. *Elwood Miller and Margaret Miller v. Mrs. William Johnson and The Allentown School of Cosmetology, Inc.,* Pa. Super., (No. 1445 Oct. Term, 1979) (Emphasis added).

*The author of the articles on these pages is the Society's legal counsel, Fred Speaker, Esq.*

# Court expands jursidiction of Act 111 arbitration panels

A court of common pleas has made a decision which expands the jurisdiction of arbitration panels under Act 111 in Pennsylvania.

Relying on the section of the Act that says that the "arbitration panel shall have original jurisdiction to hear and decide any claim brought by a patient or his representative for loss or damages resulting from the furnishing of medical services,"[1] the Armstrong County court held it had no jurisdiction over a counterclaim alleging malpractice.[2]

In the case, the hospital had sued for $763.05, the balance owed after the defendant's hospital insurance had been paid. The defendant answered by claiming that the extra amount accrued because of the hospital's negligence.

Recognizing that there were no reported cases on this issue, the court stated:

> Here, defendants are claiming as a defense that the need for extended care was caused by the hospital's negligence. However, in actuality, defendants are asserting a claim against the hospital sounding in negligence and assessing damages in an amount equal to the unpaid portion of the hospital's bill. It is not a true "defense" to the action in assumpsit, but is actually a claim for damages in trespass arising out of the same transaction or occurrence, thus meeting the requirements of a counterclaim. As a "claim" against a provider of medical services, the Administrator for Arbitration Panels for Health Care has exclusive jurisdiction in this matter. . . . This act was established to cover all allegations of negligence by patients against health care providers. Original jurisdiction over any such matter was removed from the courts and placed in the administrator under the act. We believe the act to be broad enough to include the defendant's allegations here whether they be called a "defense" or a "claim," since it is in essence an allegation that the plaintiff hospital's negligence is the cause of the injuries.[3]

Thus, in a sea of conflicting judicial opinions about the efficacy and operations of the arbitration panels under Act 111, the county court takes one stroke toward the primacy of arbitration of medical malpractice claims.

1./ 40 P.S. §1301.309.
2./ *Armstrong County Memorial Hospital v. Vitolo,* 10 D&C 3d 791 (Armstrong 1979).
3./ *Id.* at 793-4.

### Physicians may be charged for services

# Only written advance notice protects under medicare

Physicians must pay for non-covered medicare services unless they provide patients with written notification in advance that such services are not covered, HEW announced November 29, 1979. The announcement clarifies the circumstances under which medicare patients have to pay for items or services they receive which are not covered by the program.

Beneficiaries will be liable for payment only when they receive advance written notice of non-coverage from a physician, other health care provider, or an intermediary responsible for paying medicare claims, the department said (*Federal Register,* November 29). Patients are not required to pay for items or services when they had no way of knowing the services were not covered.

The clarification disallows that evidence of verbal notification of non-coverage is sufficient proof that a patient knew a service or item was not covered.

The new regulation permits medicare to reimburse the beneficiary for the amount paid, less the deductible and coinsurance, when no written notice is received. Medicare then will recover the payment from the provider. The new regulation was effective December 29, 1979.

## AMA-DE/4 available

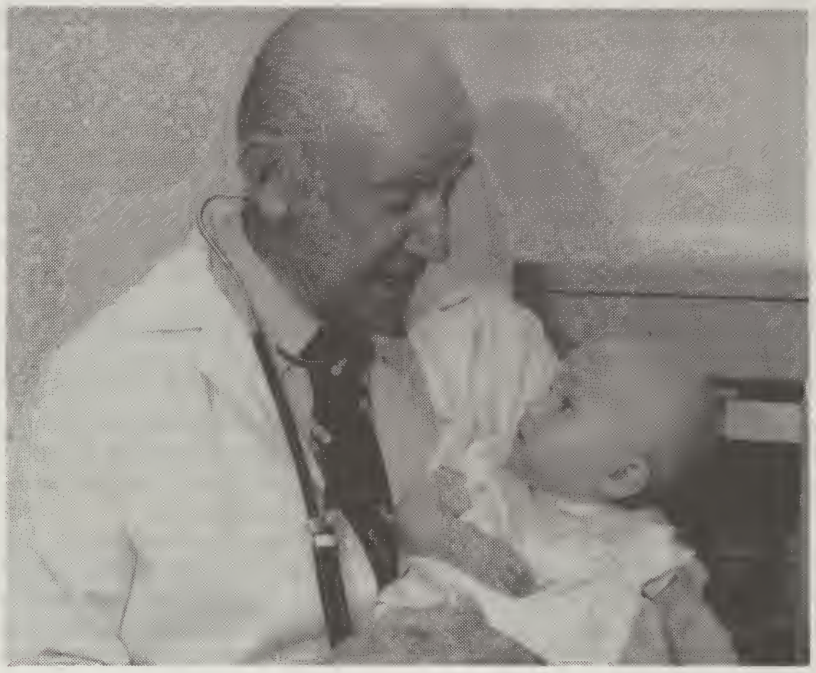
A new edition of the American Medical Association's compendium on drugs, *AMA Drug Evaluations,* will be off the press this spring.

The new AMA-DE/4 will evaluate more than 1,300 drugs, including 57 new drug listings. Reorganized and updated, the edition has chapters on antiviral drugs, drugs dealing with the body's immunine responses, products for nutrition, and agents used to treat infertility. Expanded discussions on dosages for special age groups, and information on drugs still in the research stage also are included.

The AMA-DE/4 covers the significant drugs being prescribed in the U.S. today. It is a basic guide in prescribing, dispensing, or administering drugs.

Members of the AMA's drugs department compiled the information. They worked with the American Society for Clinical Pharmacology and Therapeutics and a consulting panel of more than 300 physicians and health professionals.

The book may be ordered from Order Dept., OP-075, American Medical Association, P.O. Box 821, Monroe, Wis. 53566 at $48.00.

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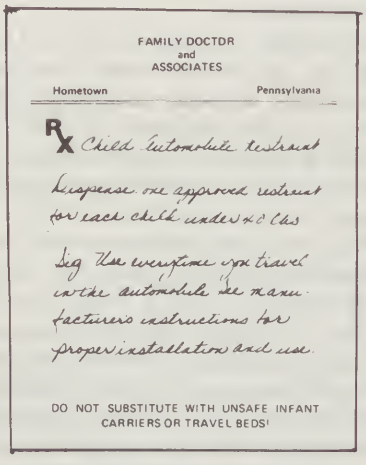


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# Psychology of chronic pain

Robert L. Gallon, PhD
Thomas Wolman, MD

Chronic pain is a frustrating problem to both patients and physicians. Patients expect physicians to cure their pain, which becomes increasingly resistant to treatment. As the pain persists, patients become progressively more preoccupied with it. Often the quality and importance of other areas of their lives deteriorate.

We will discuss pain patients, their problems, and their interactions with physicians. Also, we will propose a rehabilitative model of treatment to supplement the usual medical model. We suggest that this rehabilitative model can provide a way out of the pain dilemma.

## Overview

Pain is not a purely sensory event. Pain is a personal, psychological experience. What one person perceives as intolerable pain, another tolerates without complaint. What a person experiences as pain depends to a large extent on personal history, the context in which the pain occurs, and the individual meaning of the pain-producing situation.[1]

When considering the chronic pain patient, it is crucial to consider more than the experience of pain. We must focus our attention on the pain behaviors which constitute the sick role. Many people who suffer from pain do what they can to overcome the pain and proceed with the business of living a productive life. An unfortunate few, however, become chronic pain patients who begin to lead lives devoted to pain.

## Case 1

Like many chronic pain patients, Mary Smith has made the rounds of physicians' offices. She is addicted to medication, and is becoming progressively more disabled.

She had a four year history of low back pain following an automobile accident. She had been examined medically on numerous occasions and was hospitalized four times, once for a decompressive laminectomy. Presently she is addicted to Percodan, but the pain persists without relief.

She had tried surgeons, psychiatrists, acupuncturists, chiropractors, and hypnotists to no avail. She admitted feeling angry with all doctors because, frustrated by no results, they terminated treatment with the implication that the pain was all in her mind. Mary knew her back hurt no matter what the doctors said.

Mary's physicians may have compounded her problems by misconceptualizing her pain. In their view her pain must either be organic or psychogenic. If it were organic, they could diagnose the lesion and prescribe treatment. A psychogenic pain would be beyond their purview and delegated to psychiatric care. When her physicians dismissed Mary's pain as psychogenic, however, they led her to more doctors, more medications, and more preoccupation with the pain.

The conceptual issue is a false dichotomy, shared by both physicians and patients, between organic and psychogenic pain. Distinguishing pain as either real or imagined often only leads the patient into an argument with his doctor over the nature of the pain and decreases the likelihood of effective treatment.

A more productive approach is to consider, in all cases, the psychological and organic components of chronic pain. This approach will be more likely to encourage the patient to mobilize his resources.

## Definition

In truth, pain is always located in the mind *i.e.,* the brain. Pain is an interpretation by the brain of the information it receives from the body.

Acting as a receiver of an ongoing barrage of sensations from all over the body, the brain interprets these sensations in light of all the other information at its disposal.

Sometimes these sensations are strong and unambiguous, as, for instance, from a fresh wound. The perception of pain is clear and dominant. Even with such an immediate, strong sensation of pain, however, the character of the pain perception depends

heavily on the circumstances surrounding the pain.

In a classic study, Beecher examined soldiers severely wounded in battle during World War II.[2] He found that the soldiers acknowledged little or no pain and requested little analgesic medication. In contrast, Beecher found that hospitalized surgical patients with analogous wounds reported more severe pain.

Beecher concluded that the attitudes the two groups held toward their wounds accounted for the differences in perceived pain. The surgical patients were anxious and depressed. On the other hand, the soldiers' attitudes reflected relief and thankfulness at having escaped the battlefield alive.

If the perception of pain is so dependent on the meaning of its circumstances even under clear conditions of injury, it cannot be surprising that when the body's signals are ambiguous or unusual, the perception of pain is even more psychologically weighted. A host of factors which vary from day to day and from moment to moment determine what sensations an individual will interpret as pain at a given time. For instance, what a person perceives as an excruciating headache when he is depressed, anxious, or bored may be merely irritating when he is happy and excited.

What a person perceives as pain also depends on personality and past experience. Suppose, for example, that two men both experienced similar sensations of the head and chest at various times. Due to factors unique to him, one man focuses on the head feelings and notices every nuance of the sensation. He thinks he has chronic headaches and tries energetically to treat them. The chest sensations don't concern him much so he ignores them. The other man is distressed by the chest pain. He finds the head sensations merely bothersome. The two men present different complaints of pain because they interpret similar sensations differently.

### Attitudinal factors

People learn their overall attitudes toward pain as they interact. In our society, many learn to be sensitive to pain and to eliminate it at all cost. They tend to suspect any unusual sensations and focus attention on them.

People quickly look for medical solutions to any unpleasant sensations. When medical interventions cannot eliminate the pain, patients become anxious and demand more diagnostic testing, medication, and even surgery. If the painful sensations do not concede to a medical solution, the patient with this attitude does not look for other ways to cope with the pain and remains in distress. The pain may preempt more and more of his life and he may be unable to cope reasonably with it.

The perception of pain is first learned in the context of a family. A parent who has tension headaches has children who tend to get tension headaches rather than stomachaches. Parents who have few physical complaints tend to have children who experience few pains.

In some families, children learn to solve problems by playing sick. A child can talk himself into a headache to avoid going to school. Many adults have convenient headaches when pain can relieve them of an unwanted responsibility.

Somatic symptoms often are used as a partial excuse for not accomplishing something or to cover social anxieties. Examples are the young woman whose pain in the arm prevented her from

---

*Dr. Gallon is clinical director of psychology at Eastern Maine Medical Center in Bangor. Dr. Wolman is clinical assistant professor of psychiatry at Jefferson Medical College, attending psychiatrist at Thomas Jefferson University Hospital, and staff psychiatrist at the Veterans Administration Clinic, Coatesville-Jefferson Branch.* *This is the seventh article prepared under Dr. Wolman's supervision for inclusion in the series on office counseling for primary care physicians. The series is a project of the departments of psychiatry of the state's seven medical schools in cooperation with the Pennsylvania Psychiatric Society.*

*'Pain is a highly personal and psychological experience.'*

winning a tennis match, or the young man whose stomach cramps interefered with his ability to converse with a woman he was dating.

**Case 2**

A more radical example of pain solving life's problems is the case of John Doe. John worked as a laborer in construction and always felt frustrated and dissatisfied. His home life was unsatisfactory. He felt little closeness to his wife and felt his children were a burden. Unexpressed hostility between him and his wife marred their relationship.

When John hurt his back on the job, it was a blessing (even though he could never admit this). He started a lifelong career as an invalid. He expressed his anger at his wife and children by making them do things for him. He had an excuse to drink and to take pills; in short, a way out of anything he did not wish to do.

For pain patients like John, there are many rewards for the sick role.[3] They get attention and they are made to feel important. They can be dependent and are excused from struggling to make lives for themselves. They rely on potent medication and other people to take care of them. They have a ready excuse for moods and tempers and are not subject to the anger of others.

Although few chronic pain patients will admit any of these things, they are clearly factors in any chronic pain complaint.

Chronic pain also perpetuates itself in patients' life styles by leading them to surround themselves with buffer zones of pain behavior. These buffer zones prevent patients from experiencing the actual pain. These learned behaviors can become a greater source of disability than the pain sensations.[3]

**Emotional conflict**

Chronic pain is related intimately to emotional conflicts and the control of emotional impulses. An emotional conflict occurs when a strong emotion is blocked from expression by opposing emotions.

For instance, someone who experiences shame or guilt at feelings of sexual arousal is in conflict with the reality of his own emotions. To defend against the dangers of the physical expression of his emotions, the person is forced to dissociate from the feelings engendered by his own body.

In the extreme, the withdrawal from the real sensations of the body pushes the person into a world of illusion and image where his body sense becomes progressively more distorted. These distortions contribute to psychosomatic disorders and conversion reactions of the conflicted individual. With such distortions, a perception of pain can be elaborated from body sensations with only minimal amounts of organic pathology. Pain provides an acceptable sensation that may substitute for and defend against conflicting emotions.

Chronic pain also can be an adaptive defense mechanism of poorly controlled emotions such as rage, sex, grief, or terror. Apparently, when a person who is endangered by such conflicting emotions has an accident or injury which produces appropriately painful body signals, pain becomes a preoccupation and escalating problems of chronic pain develop. Two examples may help clarify this mechanism.

*'The character of pain perception depends on the circumstances surrounding the pain.'*

**Example 1**

Jane Doe is extremely naive and inhibited about sexual matters even though she has had three children and now cares for her baby granddaughter. As a tool for treatment, we asked Jane to keep a record of her daily activities. In her record, Jane refused to write out the word sex; however, she used a symbol to denote intercourse. She never found intercourse pleasurable, but allowed it when her husband demanded it. Nudity, even of her own granddaughter, made her uncomfortable and she would avert her eyes.

Jane seemed to spend most of her time and energy controlling sexual thoughts and feelings which were unacceptable to her. When she was in a minor automobile accident several years ago, she latched onto the resulting back pain as though it were a life preserver. Pain blocked out sexual impulses and pain prevented her from engaging in activities which would lead to sexual arousal.

**Example 2**

A second example involves Joe Brown who has a history of alcoholism and sporadic violence. In his youth Joe's violent temper involved him in many fights for which he was thrown out of several schools. Because he was small he usually ended up the one hurt.

In his early 20s Joe hurt both his shoulders. He became a chronic pain patient. He complains of unremitting pain in his neck and shoulders and only moves them with displays of effort. Doctors have told Joe that nothing is wrong and no medical treatments will help.

At his treatment sessions, Joe never expresses anger. He will not allow his voice or manner to suggest excitement which might be misinterpreted as anger. Joe does not realize that he uses his pain to prevent himself from acting on the angry and destructive impulses

that he fears may overwhelm him. Even so, he lives in a precarious balance. Occasionally he loses control, gets drunk, and begins to threaten people.

Both Jane and Joe deny impulses that are unacceptable to them. They live in constant fear of being overwhelmed by their emotions. For both of them, chronic pain is at least a partial solution. Neither could be helped by surgery or analgesic medication.

For patients like these, the answer lies in their finding ways of learning to accept their emotions and to express them in appropriate ways. With this approach, pain may no longer be a necessary coping mechanism.

**Functions**

We have examined some of the psychological issues that determine whether a sensation will be interpreted as pain, how persistent that pain will be, and whether the pain will dominate a person's life. This analysis imples that pain can become more than a safety mechanism.

From a purely physiological viewpoint, pain mechanisms are designed to protect the body against injury. Pain impels us to take action to remedy the causes of the sensation. The adaptive significance of pain is clear when we examine the continuous vulnerability to injury of people who suffer from a congenital insensitivity to pain or pain asymbolia.[1]

At the other end of the spectrum are those patients whose pain has become a way of life. It no longer seems to serve a simple protective function. Thomas Szaz calls this patient *l'homme doloreaux,* the painful person. *L'homme doloreaux* "at one time . . . may have been attornies or architects, busboys or businessmen, models or maids, but when their careers failed or no longer sufficed to sustain them, they become painful persons.[4]

These patients play the sickly role and, as Szaz notes, often become passionately attached to the pain. They can be dedicated to a pain career and often become artists at "painsmanship" to further their roles as sick persons.

**Rehabilitative model**

When physicians are confronted by a person in pain the first response, of course, is to attempt to diagnose and treat the cause of the pain. Often there is no treatable condition and no medical or surgical solution to the pain problem.

*"Chronic pain can be a defense mechanism against rage, sex, grief, or terror."*

When physicians continue to try to find a cure for the pain, or accede to the pressure to find surgical solutions, or recommend stronger analgesics, they may help develop another *l'homme doloreaux.* They help perpetuate a cycle of interactions with doctors which fosters a patient's anger and bitterness and, at the same time, encourages the patient to think he is sick.

The alternative to an unproductive medical model with these patients is a rehabilitative model. In this model the focus is no longer on cure but on finding ways to cope with pain and to lead as full a life as possible even though pain persists.

The patient can be told his tack is similar to that of an amputee. Just as no one can give the amputee his lost limb, the chronic back pain patient may never have a sound back again. He may have to live within the limitations of his disability.

The patient must be taught that his preoccupation with the pain and its cure hinders him from working hard at overcoming the affect of pain. A graduated series of physical exercises can help strengthen the muscles of the affected area and diminish the pain of disuse. Relaxation exercises and self-hypnosis can help him control the pain and break the vicious cycle of anxiety of pain.

Rather than see pain as a necessarily frightening experience to be escaped from as soon as possible, he can be taught to reconceptualize pain. Pain can be perceived as a natural life process that does not need to be suppressed by analgesics. Finally, the patient can be given a chance to explore and experience directly the emotional conflicts contributing to chronic pain.

To treat chronic pain patients appropriately, we cannot reinforce them in a sick role. When there is no medical solution, we must tell them so. Instead of feeding their fantasies of a cure, we must encourage them to find their own resources for coping with pain and getting on with the business of life.

With our guidance and understanding, they must learn to dedicate themselves to the task of rehabilitation, not cure. They must devote their energies to making the most of what they have left. Again to quote Szaz "(even) severe chronic illness does not necessarily lead to a career of pain, if the patient has something better to do with life."[4] □


**REFERENCES**

1. **Melzack:** *The Puzzle of Pain: Revolution in Theory and Treatment.* Basic Books, New York, 1973.
2. **Beecher:** Pain: One mystery solved. *Science 151:*840-841, 1966.
3. **Fordyce:** Treating chronic pain by contingency management in *Advances in Neurology.* Raven Press, New York, 1974.
4. **Szaz, T.:** The psychology of personal pain: A portrait of *l'homme doloreaux* in *Pain.* Edited by A. Soulairc, J. Cahn, and J. Charpentier. Academic Press, New York, 1968.


*"An alternative to an unproductive medical model with chronic pain patients is a rehabilitative model."*

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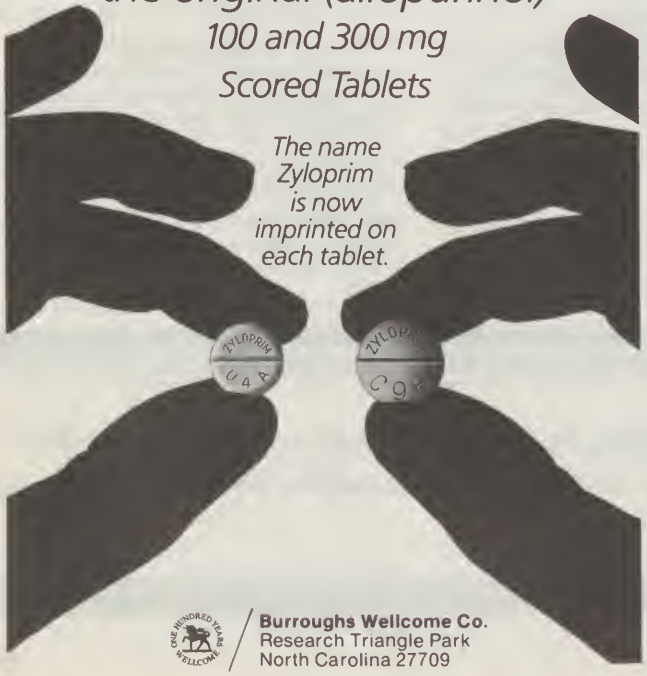


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# physicians in the news

**Donald R. Leon, MD,** has been appointed dean of the University of Pittsburgh's School of Medicine. Dr. Leon, who has been acting dean, will continue to hold his office as president of the University Health Center of Pittsburgh. Dr. Leon also serves as professor of medicine.

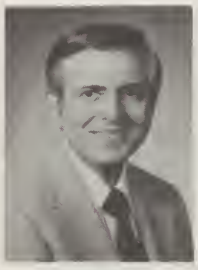
The American Biographical Institute has chosen to include **Mario J. Sebastianelli, MD,** in its eleventh edition of Community Leaders and Noteworthy Americans. Dr. Sebastianelli practices nephrology in Lackawanna County.

**Morgan T. Smith, Jr., MD,** has been named to the American College of Obstetrics and Gynecology Task Force on adolescent pregnancy. The task force will be developing a two-day program for physicians and allied health professionals to be given in six cities nationwide starting in April.

The Philadelphia Roentgen Ray Society recognized **Herman C. March, MD,** by naming its annual oration in his honor. Dr. March is a private office radiologist in northeast Philadelphia.

The American Society for Therapeutic Radiologists recently named **Sucha Order Asbell, MD,** as secretary. Dr. Asbell is chairman of the radiation therapy department at the Albert Einstein Medical Center, Northern Division. Dr. Asbell also recently received a bronze plaque from the Society for her work in a study of cancer patients.

DR. ASBELL



DR. SOLL

**David Benjamin Soll, MD,** recently received the Distinguished Alumni Award of the Chicago Medical School. Dr. Soll is professor and chairman of the ophthalmology department at Hahnemann Medical College and Hospital and director of the ophthalmology departments at Rolling Hill and Frankford hospitals and the Philadelphia Geriatric Center.

**John H. Hall, Jr., MD,** has been elected president of the American Board of Quality Assurance and Utilization Review Physicians, Inc. Dr. Hall is professor of surgery at Temple University Health Sciences Center and chairman of the board of directors of the Philadelphia PSRO.

The Uniontown Exchange Club honored **John D. Sturgeon, MD,** by inscribing his name in its Book of Golden Deeds. Dr. Sturgeon founded the pediatrics section of Uniontown Hospital and practiced privately in the community for 55 years before his retirement.

**Jack O. Greenberg, MD,** recently was elected vice president of the Society for Computerized Tomography and Neuro-Imaging. Dr. Greenberg is director of neurology at Episcopal Hospital and professor of neurology at the Medical College of Pennsylvania.

The Society of Medical Consultants to the Armed Forces elected **Charles L. Leedham, MD,** national president, at its recent meeting in Washington, D.C.

James Z. Appel, MD, (left) receives gavel of appreciation from Joseph E. Green, III, MD, vice president, Area IX PSRO.

**James Z. Appel, MD,** past president of the American Medical Association, recently ended a five year tenure as president of the board of directors of Area IX, Southcentral Pennsylvania Professional Standards Review Organization.

Dr. Appel held a firm conviction that the PSRO program offers the best, and perhaps last, opportunity for the medical profession to retain control of its own destiny.

Dr. Appel is a fellow of the American College of Surgeons and is actively engaged in private practice. He received his medical degree from the University of Pennsylvania in 1932.

**Robert M. Kemp, MD,** will succeed Dr. Appel as the new president of Area IX PSRO's board of directors.

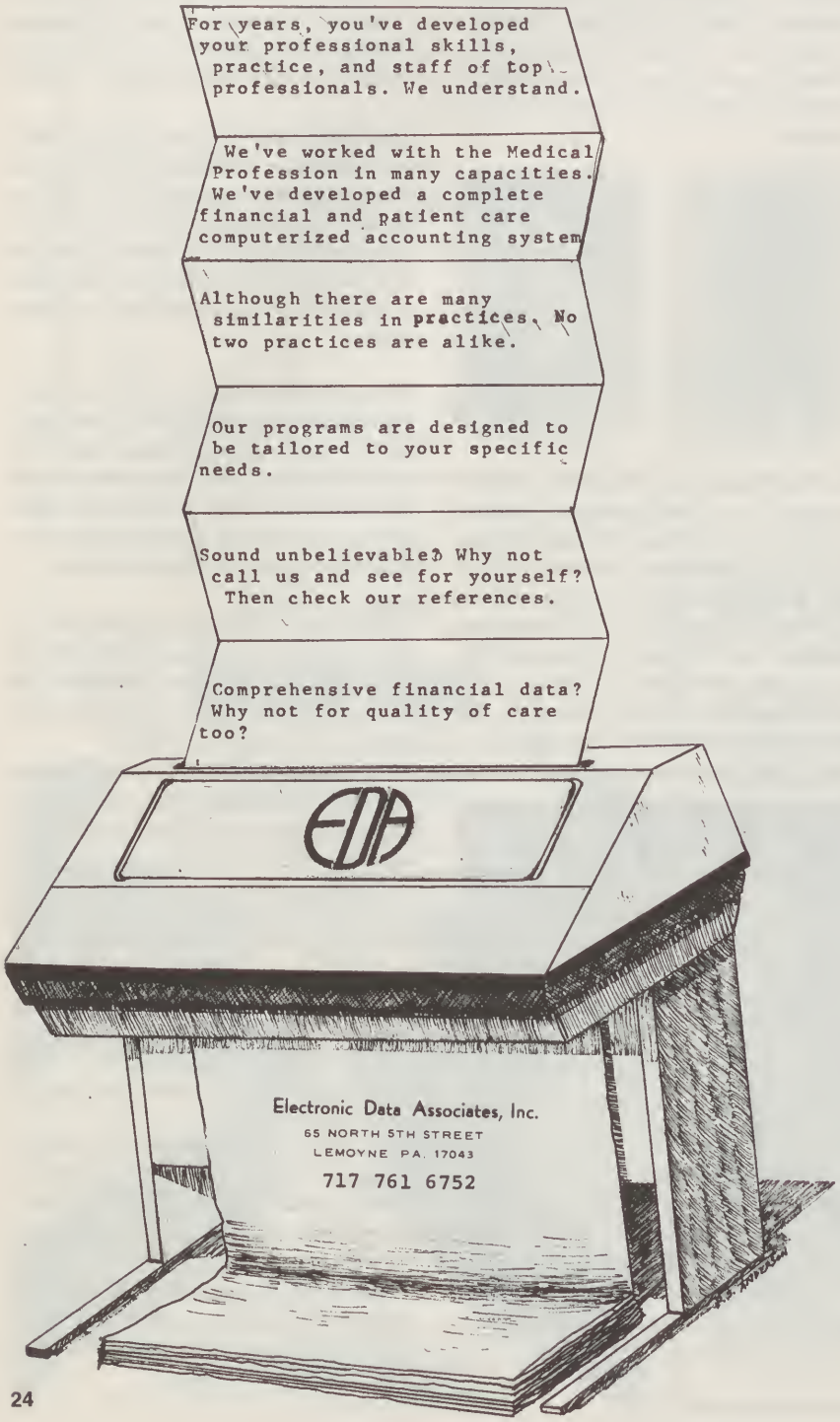
Members of the Pennsylvania Orthopedic Society recently elected **William A. Steinbach, MD,** president. Dr. Steinbach is chief of surgery at Community Medical Center in Scranton.

**Bertram Greenspun, DO,** has been named a member of the Medical Advisory Committee of the Greater Delaware Valley Chapter of the National Multiple Sclerosis Society. Dr. Greenspun is clinical director of the physical medicine and rehabilitation department at the Hospital of the University of Pennsylvania.

The American Group Practice Association recently named **John F. Rose, Jr., MD,** the first recipient of the Wallace M. Yater Medal. Dr. Rose is an associate in the urology department at Geisinger Medical Center.

**Michael Cordas, Jr., DO,** has been named to Governor Thornburgh's first Council of Sports Medicine. Dr. Cordas is team physician for the Selinsgrove high school varsity sports program.

**Mary W. Denk, MD,** recently received the Catholic University of America 1979 Alumni Achievement Award in medical arts.



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*Several county medical societies recently installed officers for 1980.*

*Adams County Medical Society elected Drs.* ***Alfredo Kaguyutan,*** *president; and* ***Bradley Hoch,*** *president elect.*

*Officers of Berks County Medical Society are Drs.* ***Cedric C. Jimerson,*** *president;* ***John C. Cottrell,*** *president elect; and* ***Lewis Pollak,*** *treasurer.*

***Aurora T. Hipolito, MD,*** *has been elected president of Clearfield County Medical Society. Other officers are Drs.* ***Edward H. Clarke,*** *vice president; and* ***Michael T. Dotsey,*** *secretary treasurer.*

*Chosen to head Jefferson County Medical Society is* ***George Fatula, MD.*** *Serving with Dr. Fatula will be Drs.* ***Steven Koh,*** *vice president; and* ***C.B. Lull, Jr.,*** *secretary treasurer.*

*Officers of the Lackawanna County Medical Society are Drs.* ***William A. Black, Jr.,*** *president;* ***Thomas H. Coleman,*** *president elect;* ***Edwin C. Neville,*** *first vice president;* ***Salvatore R. Pettinato,*** *second vice president; and* ***Thomas A. O'Boyle,*** *secretary treasurer.*

*Lancaster City and County Medical Society installed Drs.* ***Charles L. Deardorff,*** *president;* ***Charles Heisterkamp,*** *president elect;* ***Henry Wentz,*** *vice president; and* ***Roland A. Loeb,*** *secretary treasurer.*

*Re-elected to head Luzerne County Medical Society is* ***Stanley C. Ushinski, MD.*** *Other officers are Drs.* ***George Moses,*** *president elect;* ***Norman Schulman,*** *vice president;* ***Patrick DeGennaro,*** *secretary; and* ***William Boyle,*** *treasurer.*

***Donald L. Cohen, MD,*** *is the new president of Mercer County Medical Society. Other officers are Drs.* ***William Menzies,*** *president elect;* ***Bruce Wolff,*** *vice president, and* ***Robert W. Allen,*** *secretary treasurer.*

*Schuylkill County Medical Society installed Drs.* ***Richard Bindie,*** *president and* ***Michael Pristas,*** *treasurer.*

*Officers of Somerset County Medical Society are Drs.* ***Wayne McKee,*** *president;* ***George Montgomery,*** *president elect;* ***Paul Kosse,*** *vice president; and* ***James Killius,*** *secretary treasurer.*

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# in my opinion

## Second class medical care?

*Reprinted from PHILADELPHIA MEDICINE.*

Do we have second class medical care for citizens in the land of the free?

The answer to the above question, it pains me to say, is definitely, yes! Right here in our own Pennsylvania, a significant group of citizens has been relegated to second-class status in health services with the seeming approval of the state legislature.

The culprit is the commonwealth's Medical Assistance Program, which in the more than 40 years since it was first passed by the legislature, has finally succeeded in alienating a majority of the state's physicians by its indifference to present-day realities. The real victims are the medicaid "recipients," who, because of the "turn-off" of doctors, are driven to seek medical services in medicaid mills or unnecessarily expensive hospital emergency rooms.

The doctors are unhappy because they see the standards of medical care reduced to abysmally low levels by the medicaid mill operators. The increasing use of hospital emergency facilities by patients seeking services could be supplied by private physicians at one-half or one-third of the cost if the Medical Assistance Program permitted.

There is an irony in this because many doctors who still treat Medicaid patients don't even bother billing for them; the reimbursement fees are too low to warrant the clerical help to process them. They treat them as charity cases, but do not even get public acknowledgement for doing so.

The state is aware of all this but continues to impose on the doctors. Pennsylvania, because of this failure to update a law going back to the 1930s, has the lowest reimbursement rate in the nation, ranking last among the 50 states.

The State Department of Public Welfare seems indifferent to the fact that this backwardness not only results in poorer medical service to many medicaid "recipients" but also is costing the public treasury a great deal of money.

Not only do medicaid mills foist many unneeded services on the "recipients," they know how to milk a situation. Frequently, when a patient goes to a medicaid mill he or she is accompanied by other family members. The state will get dunned for each member of the family who came with the patient. It's called "gang visiting." Medicaid mills are encouraged by this sort of largely unsupervised program.

Ideally, a reimbursement system should work to insure an adequate supply of medical services, and in a measure restrain costs. Physicians would not balk at reasonable restraints on costs, but the present law provides such meager reimbursement as $6 for an office visit ($12 if the office is in a hospital). For a consultation or an initial visit in a hospital, the law permits only $10, and $3 for follow-up visits.

The Pennsylvania Medical Society has called the state's administration of the Medical Assistance Program penny wise and pound foolish, stating that it "pours more and more money into hospital care, the most expensive type of medical care, while actually reducing the amount it pays doctors," (who get only 14 percent of the total expended in the program).

The physician is demonstrably losing money under the current program. Pennsylvania Medical Society made a study of a wide spectrum of the state's doctors, and found their overhead cost averaged more than the $6 per office visit they were paid. The average doctor's overhead was found to be $6.97, representing a loss to him of 97 cents per patient visit. The largest loser was the big city internist whose overhead came to $14.35, more than double the fee the state allowed him. These figures help explain why only 46 percent of Pennsylvania physicians participate in the state medical program, versus 66 percent nationally.

Can anything be done about the situation? The Pennsylvania Medical Society has formed a Medical Assistance Liaison Committee to review the system and try to find a way to start correcting the glaring inequities.

Those with the most to gain are the intended recipients of the medicaid program—the second class citizen of medical care. Reforming the law would permit those on medical assistance to seek and receive the highest quality medical care available. Then they will be restored to first class medical citizenship.

Robert S. Pressman, MD
First District Trustee
Philadelphia

## 123-I uptake in newborn questioned

Many of us question the necessity for 123-I uptake on the newborn with primary thyroid failure as reported in "Management of congenital hypothyroidism" by John Parks, MD in the October issue of PENNSYLVANIA MEDICINE.

In my opinion, this study assists in evaluating the etiology of the primary thyroid failure but does not alter the therapeutic program. Although I-123 has a significantly

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The National Cancer Institute has developed a free "Helping Smokers Quit" kit to help you answer the "how" and to help your patients quit the smoking habit. Materials for this kit were pretested with the cooperation of the Harris County (Texas) Medical Society and M.D. Anderson Hospital and Tumor Institute in Houston, Texas.

The National Cancer Institute will provide the "Helping Smokers Quit" kit free of charge to all physicians who want to participate in this important effort. Included in the kit are guidelines for physicians, a self-test to help smoking patients determine why they smoke, pamphlets with tips on quitting, and waiting room posters to introduce the subject. Each kit contains enough materials to help 50 of your smoking patients who want to quit.

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lower radiation dose to the thyroid, nevertheless, it does deliver measurable quantities. This, coupled with the realization that the data derived will not alter the therapeutic program, seems therefore to be unnecessary.

If the etiology is important to establish, the youngster can always be studied years later.

I welcome Dr. Parks' comments on this.

George L. Jackson, MD
Harrisburg

## Psychiatrist answers psychologist

Two items in Dr. Michael J. Asken's article which appeared in the November 1979 issue of PENNSYLVANIA MEDICINE lead me to take issue with this psychologist.

First, his title, "Psychological stress in ICU affects both patients, staff" is offensive as I feel it is fairly obvious to anyone that there is stress upon both the patients and the staff of an ICU unit.

Second, his statement on page 42, "a mistake often made is to bring in a group leader such as a psychologist, social worker or even a psychiatrist, who, while skilled in group techniques, has a basic ignorance of the medical or hospital milieu." Although I take issue on this, I would embarassedly state that I might agree that there are psychiatrists who have a "basic ignorance of the medical or hospital milieu." However, I feel that any psychiatrist who would fall into the category of being basically ignorant of the medical or hospital milieu should either obtain the training to correct this or should not have gone to medical school in the first place and probably should be a psychologist.

Hilbert E. Oskin, MD
Latrobe

## Author reacts

To the Editor:

I thank Dr. Oskin for his interest in my article and appreciate the opportunity to reply. As to his first point, editorial changes apparently produced the title which I might agree is somewhat overgeneralized (as the article focuses mainly on nursing personnel) but is questionably "offensive." Additionally, the continued problem of such stresses and the frequent reluctance to intervene or change the salient aspects of such units raises some question as to whether the stresses are indeed "obvious to anyone."

As to Dr. Oskin's second concern, I believe that we are in essential agreement. The tremendous interest and development of Behavioral Medicine and Medical Psychology which has occurred in recent years has led to a bandwagon atmosphere among mental health and medical professionals believing that almost anyone is qualified to deal with psychological aspects of medicine and health behavior. The statement to which Dr. Oskin refers is meant as a caveat (not a slur) to individuals or hospitals hiring professionals for such positions to assess congruence with working in a medical milieu.

Finally, I must take exception to Dr. Oskin's concluding statement. Since its beginning Behavioral Medicine (and Medical Psychology) has been a cooperative interdisciplinary endeavor which has done much to bring psychology and psychiatry together. I am sorry and disappointed Dr. Oskin's comments would end in a tone representative of the attitudes which would split an amalgam so potentially beneficial to both disciplines, medicine, and patient care.

Michael J. Asken, PhD
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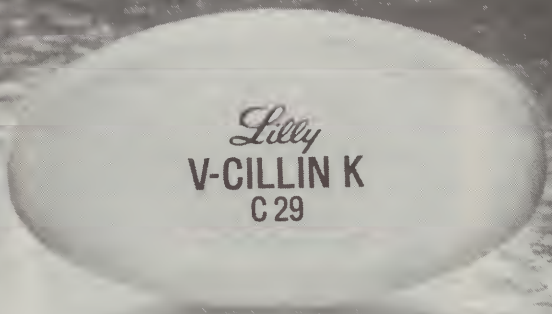


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# Salvaging lower extremities of diabetics

**Frederick A. Reichle, MD**

Approximately six million Americans suffer from diabetes mellitus. A well established association exists between diabetes and increased incidence of premature vascular disease such as coronary artery disease, retinopathy, nephropathy and extremity ischemia secondary to peripheral arteriosclerosis obliterans. Arteriosclerosis obliterans is a common cause of morbidity and mortality in diabetics.

In our experience, almost one-half of all patients with symptomatic peripheral vascular disease are diabetic. Despite the traditional belief that arterial reconstruction plays a limited role in diabetics our experience shows that limb salvage can be achieved in most diabetics by revascularization of severely ischemic limbs by bypasses to either popliteal or infrapopliteal (tibial, peroneal) arteries.

### Characteristic history

The diagnosis of lower extremity arterial insufficiency almost always can be established by history and physical findings alone; expensive equipment is not necessary. The history of intermittent claudication, *i.e.* pain during exercise which limits the ambulation distance, is a characteristic early symptom in many patients.

More severe arterial insufficiency may be manifested by rest pain which can be suspected strongly by the distal distribution of pain, particularly in the toes and distal feet. Patients experiencing rest pain typically report pain after reclining at night and concommitant relief upon assuming a dependent position. When sitting at the bedside or assuming an erect position relieves night pain, the lower extremity pain is likely to be secondary to arterial insufficiency.

Neuropathy usually can differentiate lower extremity pain from ischemic symptoms by the longitudinally-directed lancinating and burning nature of neuropathic pain and by the presence or absence of the characteristic physical findings associated with ischemia.

### Physical findings

Physical examination can be performed easily and quickly in the office. The adequacy of arterial perfusion should be assessed in both diabetic and non-diabetic patients suffering from lower extremity pain. First the presence or absence of extremity pulses should be determined.

Pallor on elevation or rubor of dependency also should be tested. To determine whether or not pallor of elevation develops, elevate both lower extremities for 30-60 seconds. After this elevation, ask the patient to sit up and promptly put both lower extremities over the side of the examining table in a completely dependent position.

Two parameters should be observed: the duration of venous filling, and the presence or absence of developing rubor of dependency. When severe ischemia is present, a paradoxical rubor usually develops in the same extremity where pallor developed when the extremity was elevated. Rubor may develop promptly or it may require one or two minutes of dependence to become apparent.

The demonstration of pallor of elevation with rubor of dependency in a patient who is suspected of arterial insufficiency unquestionably confirms the diagnosis. The findings are reliable and reproducible. These maneuvers on physical examination take only a short time and do not involve any invasive or costly techniques. These findings tell the clinician more about the adequacy of arterial nutrition of the lower extremity than any other available tests. They should be performed whenever arterial insufficiency is suspected.

Venous filling time is the time required for filling of the superficial veins after an elevated extremity suddenly is placed in a dependent position. It is observed best over the dorsum of the foot. The venous filling time

***Figure 1a.*** **Severe ischemia with gangrene in diabetic patient. The primary etiology is arterial insufficiency manifested by cool extremity, pallor of elevation, and no palpable distal pulses. Diabetic control was attained, and arteriography was performed. Bypass to distal anterior tibial artery just above the ankle was performed using autogenous saphenous vein graft. Debridement was deferred until early graft function had been established.**

*Dr. Reichle is a member of the surgery department at Presbyterian Hospital of the University of Pennsylvania.*

*Figure 1b.* Several days postoperatively the resection of the gangrene was performed. Within seven days, a granulated base indicated pedal arterial nutrition, fibroblastic activity, and collagen production. Such granulation tissue, which would not be produced in the presence of severe arterial insufficiency, serves adequately as a bed for routine skin grafting.

*Figure 1c.* Split thickness skin graft can be expected to survive only when revascularization by previous arterial reconstruction has been performed. The healing incision (proximally on the right) indicates the site of distal anterior tibial bypass.

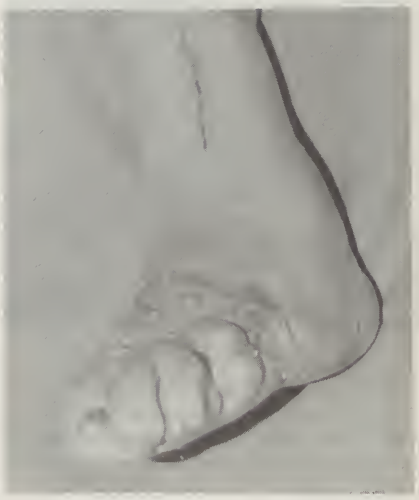

*Figure 1d.* The foot is functional and previously gangrenous areas are covered. Prolonged hospitalization was necessary yet the total medical care expended was less than that for primary amputation. (Mortality of attempted limb salvage by arterial reconstruction is less than mortality of primary amputation. The aftermath for the amputee is far more taxing physically and emotionally.)

is reproducible and has a clear-cut endpoint.

Prolonged venous filling time is significant. It indicates arterial insufficiency and represents an increased transit time from the arterial bed through the capillary bed and into the venous channels.

Venous filling time can be determined easily by inspecting the dependent extremity in adequate lighting conditions. Normally venous filling time is 10-15 seconds.

Although prolonged venous filling is almost always significant, when venous filling time is normal and other criteria of arterial insufficiency are present, the venous filling time may be falsely negative. Venous valvular incompetency causes a false negative (normal, less than 10-15 seconds) venous filling test, in which the venous filling time is normal and arterial insufficiency is present. In this situation venous blood refluxes down the veins into the extremities filling the superficial veins promptly. This does not test the capillary transit with subsequent venous filling but rather represents pathologic venous valvular mechanisms.

These simple, rapid, and safe maneuvers are important in managing the diabetic patient because they determine the presence or absence of arterial insufficiency. The diabetic is particularly prone to non-healing ulcerations and necrosis on the basis of microangiopathy or altered tissue responses even though the larger arteries, the femoral, popliteal, tibial, and peroneal, are patent, and distal pulses are present. When chronic occlusion of a large artery causes necrosis, pallor and paradoxical rubor will be observed.

In assessing the diabetic patient with necrosis, the temperature of the foot is important. When the foot is warmer than normal, infection may be the primary etiologic mechanism. When the foot with gangrene or ulceration is cool, arterial insufficiency is almost certainly the primary etiological factor and should be investigated further by arteriography.

### Assessing the etiology

Differentiating necrosis on the basis of infection from necrosis on the basis

*Figure 2a.* Diabetic patient with rest pain. Occlusion of distal superficial femoral artery and chronically occluded popliteal artery precluded proximal arterial reconstruction. Distal bypass was constructed using reversed autogenous saphenous vein graft.

*Figure 2b.* Vein graft was performed across the knee joint in the usual position of the popliteal artery, and then tunneled anterolaterally through the proximal cleft in the interosseous septum into the anterior compartment of the lower extremity.

*Figure 2c.* Anastomosis to the anterior tibial artery was performed and revascularization of the distal extremity relieved rest pain.

of microangiopathy or necrosis associated with large arterial occlusion with extremity arterial insufficiency, is essential in the diabetic patient.

Infection as an etiological factor can be suspected not only by the presence of a warm foot, but also by a malodorous drainage or fluctuation indicating that infection with abscess formation may be present. Therapy then should include early drainage of infection. Assessing the healing propensity of the area of the drained wound subsequently will allow assessment of the status of arterial sufficiency or insufficiency.

When there are no signs of infection but the diabetic patient has tissue necrosis and associated pallor of elevation with rubor of dependency, plans for arteriography with subsequent consideration to arterial reconstruction should be made (Figures 1 and 2).

Arteriography is not performed to establish the diagnosis of arterial insufficiency. The diagnosis is determined by the physical findings. The arteriogram defines the exact pathologic anatomy of the arterial lesion and is critical in planning operative arterial reconstruction.

### Arterial reconstruction

Threatened loss of tissue frequently indicates the need for surgery in diabetic patients with arterial insufficiency. Intermittent claudication alone, with ischemic necrosis or rest pain, is a relative indication for operation in diabetic and non-diabetic patients.

Revascularization of the severely ischemic lower extremity in the patient with claudication alone is considered when claudication is severely limiting. Patients with either rest pain or ischemic necrosis imminently require revascularization or amputation.

Previously, patients with ischemic necrosis or rest pain and diabetes mellitus were thought to have remote chances of limb salvage and to be inoperable. Our experience demonstrates that the diabetic patient does stand a substantial chance of limb salvage and that the presence of diabetes mellitus *per se* does not contraindicate operation to provide revascularization and to attempt to avoid extremity amputation.

We have performed arteriograms in almost all diabetic patients with rest pain or ischemic necrosis to determine the feasibility of limb salvage. In approximately 90 percent of the patients, attempted limb salvage by arterial reconstruction is indicated.

### Preoperative arteriogram

Preoperative arteriography is performed in all patients with severe extremity ischemia to determine the patency of the distal vasculature. Our criteria for evaluating the adequacy of the arteriogram in patients in whom a major artery does not visualize is demonstration of small, unnamed collaterals in the region of the major artery occlusion.

The arteriogram is invaluable in determining the type of arterial reconstruction indicated. For example, when the popliteal artery fills beyond the occluded superficial femoral ar-

tery, a femoropopliteal bypass may be indicated. When the popliteal artery does not visualize on adequate arteriography, in the diabetic patient with severe ischemia, tibial or peroneal artery bypass may be indicated.

### Prevalence of diabetes

Diabetes mellitus was present in 197 out of 474 (41.6 percent) patients in whom arterial reconstruction was required. In patients in whom bypasses were performed to the popliteal artery, femoropopliteal bypass, diabetes was present in 116 out of 316 (36.7 percent). In patients who required femoro-infrapopliteal bypass (popliteal artery was occluded chronically by atherosclerosis obliterans) the incidence of diabetes mellitus was 81 out of 164 (49.4 percent).[1]

### Indications for operation

Severe, limb threatening arterial insufficiency was manifest by gangrene in 147 out of 474 (31 percent), by ischemic ulceration in 100 out of 474 (21.1 percent), and by rest pain in 178 out of 474 (37.6 percent). Intermittent claudication was the operative indication in 49 out of 474 (10.3 percent).

When patients develop ischemic necrosis or rest pain, an operation usually must be performed without delay. When claudication alone is present, the advisability of operation can be decided on an individual basis. The extent of impairment to the patient's lifestyle must be considered carefully. Vasodilators are generally ineffective in both claudication and the more severe forms of arteriosclerosis obliterans.

### Operative results

Limb salvage was achieved in 257 out of 310 (82.9 percent) patients after femoropopliteal bypass and in 112 out of 164 (68.3 percent) patients after femorotibial bypass. Success of revascularization of limbs after femoropopliteal arterial reconstruction is approximately 15 percent less in diabetic than in non-diabetic patients.[2]

Although approximately 70 percent of the patients have clinical manifestations of organic heart disease, and almost one-half have hypertension, the mortality of revascularization procedures is generally lower than mortality of primary amputations.[3] Mortality occurred in 20 out of 474 (4.2 percent) diabetics and non-diabetics.

### Conclusion

Arterial insufficiency of the lower extremity, commonly associated with diabetic patients, can be managed successfully with revascularization by arterial reconstruction. Revascularization should be performed before prolonged rest pain results in deterioration of general health and before extensive tissue injury prohibits limb salvage.

Diabetes mellitus should not preclude thorough clinical and arteriographic evaluations and arterial reconstruction for limb salvage in lieu of primary major amputation of the lower extremity. □

### REFERENCES


1. **Reichle, F.A., Rankin, K.P., Tyson, R.R., Finestone, A.J., and Shuman, C.:** Long-term results of 474 arterial reconstructions for severely ischemic limbs: A 14 year follow up. *Surgery, p:*93, 1979.
2. **Reichle, F.A., Rankin, K.P., Tyson, R.R., Finestone, A.J., and Shuman, C.R.:** Long-term results of femorotibial bypasses in diabetic patients with severe ischemia of the lower extremity. *Am J Surg,* 1979. (In Press)
3. **Reichle, F.A and Tyson, R.R.:** Femoroperoneal bypass: Evaluation of potential for revascularization of the severely ischemic lower extremity. *Annals of Surgery 181:*182-185, 1975.



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# practice management

## Corporation partnership—dramatic new advantage

**Leif C. Beck, LL.B., CPBC**
**Vasilios J. Kalogredis, JD, CPBC**
**Geoffrey T. Anders, JD, CPA**

We reported the new concept of the professional corporation as a partner in the May issue of PENNSYLVANIA MEDICINE. This concept offers a unique solution to one dilemma of the group practice, specifically, fulfilling the different tax and retirement funding desires of each physician member.

For example, a partner in a group which does not wish to be a professional corporation could incorporate himself. His solo corporation could be his "partner" and determine its own retirement plan contribution level.

An incorporated group could reorganize into a number of solo corporations, with each corporation setting up its own pension and/or profit sharing plan. Each physician could determine his own salary level and extent of retirement funding, a manner of individualizing the members' financial and tax planning.

The IRS essentially had recognized this concept so long as each corporate partner included and contributed proportionately for the staff who typically became employees of the partnership, not of the corporations. This requirement presented some practical administrative problems. Legal and accounting fees, and retirement plan administration expenses would require substantial monies. Only when large dollars were involved or when no other strategy could reconcile the members' financial concerns would this approach be worthwhile.

On page 46 of the October issue of PENNSYLVANIA MEDICINE, the principal consultants of Management Consulting for Professionals, Inc., reported "Tips for retirement plan distributions." Upon review, the authors noted an error under the heading "Estate tax impact."

The first paragraph should read:

*Generally, a* **non-lump sum distribution,** *based upon employer contributions, from a qualified retirement plan on account of death will be fully exempt from federal estate tax under present law.*

### New development

In mid-October, two striking court decisions were issued which will encourage doctors to take the partnership of professional corporations approach. These two decisions hold that a corporate partner need not include the partnership's staff employees in its pension and/or profit sharing plan. The opportunity for dollar savings by excluding them could be dramatic.

In *Lloyd M. Garland, MD, FACS, PA,*[1] the physician had personally been a partner with another doctor until he separately incorporated and caused his corporation to become the partner. Dr. Garland's corporation then adopted a pension plan which after the Pension Reform Act of 1974 ("ERISA") was amended to cover only Dr. Garland. The staff employees were not included since they continued to be employed by the partnership, not by Dr. Garland's corporation.

The Tax Court approved Dr. Garland's corporate retirement plan even though it excluded lay employees. The court recited that the corporation did not control the partnership, neither as a matter of general law nor as specifically defined in the tax law, since the corporation was not a greater than 50 percent partner.

### Implications

Under this legal position, a group of physicians could exclude its staff from retirement plan coverage by creating a partnership of their separate solo corporations. A member of an unincorporated group could incorporate himself and contribute to pension/profit sharing only for himself. Thus,

*The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.*

[1] 73 Tax Court decision No. 2, filed October 4, 1979. The other decision was similar though based on pre-ERISA law. It had been decided last year as *Thomas Kiddie, MD, Inc.*, 69 Tax Court 1055 (1978), and the Ninth Circuit Court of Appeals has just refused the IRS' appeal. Thus, a higher court essentially has taken the same favorable position.

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the thousands of dollars typically required to cover all employees on a proportionate basis could be saved.

Although the IRS may appeal the *Garland* decision, we believe the decision is legally correct and will stand. Such employee exclusion is an acceptable tax risk for groups having compelling reasons to become partnerships of professional corporations. One must, of course, critically consider the effect on staff morale and on the inter-doctor relationships if separating into individual corporations.

The potential savings might justify the substantial legal, accounting, retirement plan administration, and other costs of creating and maintaining such a multi-corporation arrangement. Physicians who previously hesitated to undergo those costs now may find them acceptable. And a high-income physician wishing to deflect dramatic amounts of his income to retirement (perhaps through a defined benefit pension plan keyed to his age) now may be willing to assume more than a pro-rata share of those costs since his potential advantage will be greater.

**Continuing concerns**

We believe the new decisions will influence many physicians to switch over to the partnership approach, but there are still serious concerns. First, the IRS probably will continue to resist excluding staff employees. One alternate attack would be the underlying intercorporate partnership agreement. None of the decisions has considered whether a corporate partner or the physician is the actual earner of the partnership income. Creating a partnership, capable of withstanding such attacks, will require particular experience and care; too much is involved for casual handling.

Second, we think the result of these tax court decisions will be considered repugnant to the overall intent of tax-favored retirement plans. Undoubtedly there will be proposals in Congress to change the law.[2] Tax law changes, however, are typically prospective in their application so that the savings accomplished before any deadline would not be lost. We see the likelihood of legislation as a strong reason why groups considering a corporate partnership approach should move quickly.[3]

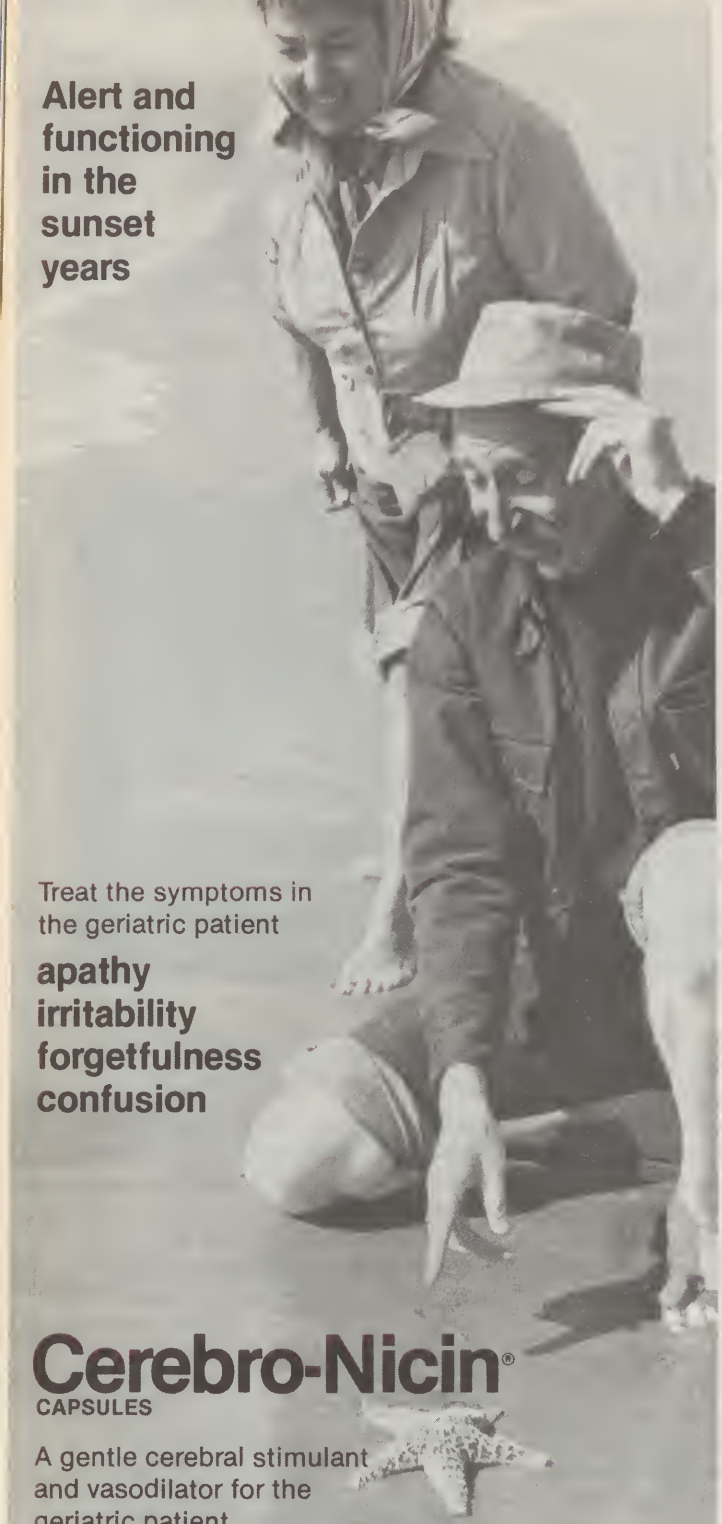
Third, all the inter-physician group practice concerns, the personnel management effects, and the cost considerations previously discussed must be weighed. The corporate partnership relation will be worthwhile only when it does not interfere with a successful practice. This necessary perspective is another reason why conscientious, impartial advice is essential.

**Conclusion**

The corporate partnership now becomes an opportunity both for legitimate inter-physician flexibility and for substantial dollar savings. But its dramatic aspects also demand perceptive evaluation and extreme care in handling the details. The rewards can be greater than anticipated; but they can easily be lost.

[2]Since writing this article, the authors have learned that such legislation has been proposed. They believe it is likely to pass and become law.

[3]The net effect for some groups may be to offset the heavy first-year fees of creating the arrangement against the first year's retirement plan saving. If the tax law thereafter requires proportionate coverage of the partnership's staff employees, that ongoing situation then should be acceptable.



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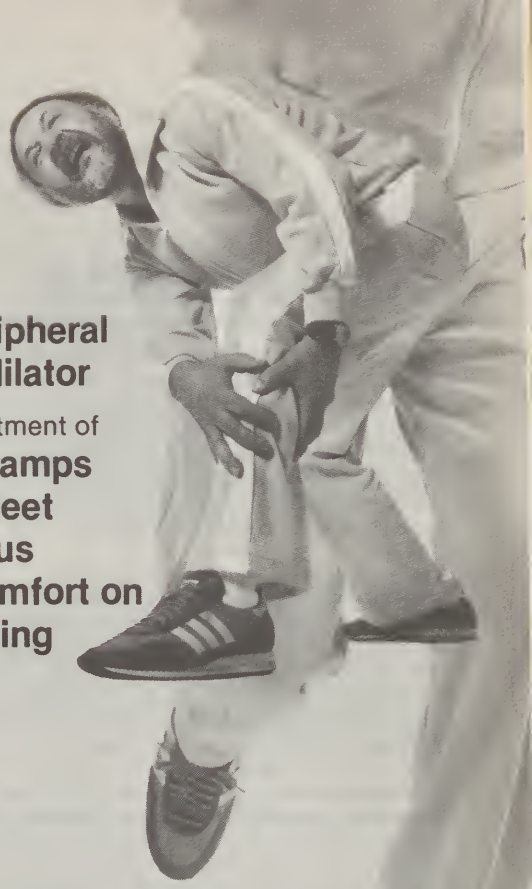

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Case report

# Subclavian vein thrombosis manifested clinically

**Francis C. Au, MD**
**Howard Edington**
**Robert D. Harwick, MD**

Total parenteral hyperalimentation in surgical and cancer patients often is indicated and the reasons have been documented extensively.[1] Central venous thrombosis is a recognized complication of subclavian catheterization; however, few cases of clinically apparent thrombosis have been reported in the English literature.

## Case report

A 57-year-old black male had a laryngo-pharyngo-esophagectomy and a left radical neck dissection on April 26, 1978 for carcinoma of the cervical and upper thoracic esophagus with left cervical metastases. The stomach was migrated up to the cervical area to be anastomosed to the remaining portion of the oral pharynx.

He was discharged on May 31, 1978 on a regular diet, but he could not maintain his weight during post operative irradiation treatments to the cervical and thoracic areas. During the fourth week of irradiation, he had a ten pound weight loss.

On June 30, 1978, he was readmitted. Entero-hyperalimentation initially was implemented but subsequently was discontinued due to intolerance. Total parenteral hyperalimentation was instituted on July 1, 1978.

A polyethylene catheter was inserted via a left infra-clavicular subcutaneous puncture without complication. A radiograph showed that the catheter tip was placed correctly within the superior vena cava. A solution of 50 percent dextrose and synthetic amino acids plus necessary electrolytes and vitamins was infused.

The patient tolerated hyperalimentation well initially and steadily gained weight. On July 12, 1978 a sudden onset of edema was observed in the left upper extremity. The patient reported that no pain accompanied the swelling. Moderate venous congestion and normal arterial pulses were noted.

A venogram demonstrated a total thrombosis of the left subclavian (Figure 1). The left subclavian catheter was removed and a right subclavian catheter was inserted to continue hyperalimentation.

The patient was started on heparin 5,000 units intravenously every six hours and his left upper extremity was elevated. With this treatment, his edema eventually subsided.

## Discussion

Many factors have been implicated in the etiology of thrombosis secondary to central venous catheterization. A catheter present in a small diameter vein or a peripheral vein, either of a child or of an adult, may cause intimal damage and subsequent thrombosis.[2] Bacterial and fungal sepsis, venous stasis, and low pH and hypertonicity of the infusate are other predisposing factors.[3]

A coagulation disorder prior to catheter placement increases the probability of thrombosis. Hypercoagulability has been associated with certain cancers and the use of oral contraceptives. Irradiation to the vessels can cause transmural changes in the vascular wall, and lead to thrombosis.[4]

The events leading to catheter-related thrombus formation are not certain. Probably the catheter itself is thrombogenic and the initiating event is a fibrin sheath, described by Hoshal,[5] forming around the catheter.

Any of the previously mentioned factors may exacerbate the event. In this patient, probably irradiation to the subclavian vessels that were included in the portal of radiation was the most significant complicating factor.

The likelihood of central venous thrombosis should depend on the number and on the severity of predisposing factors. This reason partly accounts for a disagreement in the literature concerning the incidence of thrombosis.

Christensen, *et. al.*, in reviewing 1570 cases of subclavian catheteriza-

*Figure 1* **Total thrombosis of the left subclavian vein starting from the site of catheter insertion. Note the venous drainage through collaterals.**

*The authors are from the surgical oncology section of the surgery department at Temple University School of Medicine.*

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tion reported an incidence of thrombosis of 0 percent.[6] Warden, *et. al.*, whose study involved a population of burn patients, reported an incidence of 36.7 percent.[7] The literature notes that burn patients have a greater preponderance of thrombogenic factors, and therefore, Warden's results should not be considered representative of other patient populations.[8]

Numerous studies using postmortem examinations have indicated that thrombosis is present in a far greater amount of cases than it is clinically evident.[3,9] Indeed, the incidence of clinically manifested thrombosis is low.

Using heparin concurrent with total parenteral hyperalimentation has been advocated.[10] The significant incidence of subclinical thrombosis suggests that prophylactic heparin should be used in patients at high risk.

When thrombosis occurs, the recommended treatment is immediate removal of the catheter, anticoagulation, and elevation of the limb. Anticoagulation facilitates lysis and prevents extension of the thrombus.

Pulmonary embolism does occur secondary to subclavian vein thrombosis. Although it is rarely fatal by itself, pulmonary embolism has significant morbidity and may contribute to fatality. □

### REFERENCES


1. **Copeland, E.M., MacFayden, B.V., McGowen C., Dudrick, S.J.:** The use of hyperalimentation in patients with potential sepsis. *Surg Gyn Obstet 138:*377-380, 1974.
2. **Wigger, H.T., Bransilver, B.R., Blanc, W.A.:** Thromboses due to catheterization in infants and children. *J Pediatr 76:* 1-11, 1970.
3. **McDonough, T.T., Altemeier, W.A.:** Subclavian venous thrombosis secondary to indwelling catheters. *Surg Gyn Obstet 133:*937-400, 1971.
4. **Mustard, J.F., Murphy, E.A., Rowsell, H.C., Downie, H.G.:** Factors influencing thrombosis formation in vivo. *Amer Med 33:*621-647, 1962.
5. **Hoshal, V.L., Ause, R.G., Hoskins, P.A.:** Gibvin sleeve formation on indwelling subclavian central venous catheters. *Arch Surg 102:*353-358, 1971.
6. **Christensen, K.H., Nerstrom B., Baden H.:** Complications of percutaneous catheterization of the subclavian vein in 129 cases. *Acta Chiv Scand 133:*615-620, 1967.
7. **Warden, G.D., Wilmore, D.W. Pruitt, B.A.:** Central venous thrombosis: A hazard of medical progress. *J Trauma 13:*620-625, 1973.
8. **Havill, T.H.:** Central venous thrombosis following central venous catheterization and parenteral nutrition: Case report. *N Z Med J. 81:*420-422, 1975.
9. **Ryan, T.A., Abel, R.M., Abbot, W.M., et. al.:** Catheter complications in total parenteral nutrition. *N Eng J Med 290:*757-761, 1974.
10. **Nordlund, S., Thoren, L.:** Catheter in the superior vena cava for parenteral feeding. *Acta Chiv Scand 127:*39-45, 1964.

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**Dosage and Administration:** *Adults:* Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg./ml., but not to exceed 20 mcg./ml.

*Dosage in Children:* Usual dosage should be based on administration of 10 mg. per kg. per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

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[1] Tinkelman, D.G., Carfoll, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. Medical Challenge 10:24-26, 1978.

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# Stroke rehabilitation in midwestern families

**Glen P. McCormick, PhD**
**Martha M. White, MEd**
**Linda J. Dorst**

Throughout 1974, nurses from midwestern Pennsylvania appealed to the staff of the Midwestern Pennsylvania Chapter, American Heart Association (AHA), for improved services for the families of stroke victims from the region surrounding Butler. The nurses made their requests after seeing families suffer from the cumulative distress peculiar to the management of stroke victims in ordinary households.

### The stroke club

By the end of that year, AHA staff members had joined forces with clinicians from the Butler Veterans Administration Medical Center to form the Midwestern Pennsylvania Stroke Club. The Club was charged with providing practical assistance to the families of stroke victims via monthly meetings. At the meetings, volunteer speakers from the adjacent health care community provided formal presentations followed by brief social periods and ended with informal questions and answer sessions.

The Club met first in January 1975 with 13 families present. For the first six meetings, stroke victims were separated from their spouses during the question and answer sessions. This arrangement allowed the spouses more freedom to reveal their problems without disturbing the stroke victims.

Although the primary goal of the Club has been to provide practical information to family members caring for stroke victims, an unexpected and unique by-product has been the enlightenment of clinicians who have developed an appreciation for the plight of these family members. This report addresses the more troublesome problems of families caring for stroke victims in their homes.

*The authors are with the Audiology and Speech Pathology Service at the Veterans Administration Medical Center, Butler.*

### Problems

The largest problem facing stroke families is the unexpected disparity between acute and rehabilitative periods of management. Specifically, the acute period of stroke care tends to be directed professionally, limiting family members' exposure to patients. Although this portion of patient care is tense for families, their role is played frequently in the sterile confines of a special medical unit. The health specialists peculiar to this phase of management generally win the praises of the families receiving care.

The period of post-acute care—stroke rehabilitation—has been declared more theoretic than real. During this period of patient management, debilitating family events begin to develop. Too few stroke families from the general community have been exposed to organized stroke rehabilitation to compare the lasting effects of acute versus rehabilitative forms of treatment.

Since the Club functions in a community served by a Veterans Administration medical facility boasting an organized stroke recovery unit, veteran and non-veteran families routinely populate the Club. Acute care alone has been available for non-veteran families. Thus we can compare stroke victims and their families receiving acute care primarily and those receiving both acute and rehabilitative. Families who have not received stroke rehabilitation services are found more often to be "in crisis," particularly as they begin Club activities.

### Activities of daily living

For "in crisis" families specifically, special reference must be made regarding the concept: Activities of Daily Living (ADL). ADL independence is the goal of most stroke patients who are not totally disabled. The ADL concept also serves as a reference point for releasing the patient to family management.

After four years of Club involvement, we feel obligated to report that the level of ADL independence, for the typical, non-veteran patient is minimal. The ADL inabilities seem to result from a variety of causes: too little contact with clincians, vague-to-no direct referral to clinicians once the patient leaves acute care, weather and/or transportation barriers which influence outpatient services, etc. Whatever the causes, much of the suffering imposed upon stroke families could be minimized if ADL independence were demanded more rigidly, and if follow-up care were extended formally to the stroke victims upon release from acute care.

The features included in ADL are physical in nature—walking, toileting, bed-to-wheelchair transfer, etc. No one disputes the necessity for success in physical capabilities. But, the Club's member-spouses unanimously stipulated that the all-important issue of the patient's emotional condition must be considered.

Virtually all the spouses in the Club can manage the physical and communicative disturbances secondary to stroke, but gradually and incessantly they are destroyed by the unexpected and seemingly irreversible emotionalism of the stroke victims. Patients and spouses have indicated that unresolved emotional issues divide their allegiance to each other, and strain the integrity of the marital bond. Often this results in requiring more frequent medical services for patient and spouse, with a preponderance of health complaints for ailments of an emotional rather than physical nature.

Although strokes can impose severe strains on lay caregivers, the spouses in the Club have shown an admirable interest in getting stroke victims home and for keeping them there. In the absence of professional counseling and guidance, the extreme strain of this responsibility could overwhelm even the best intentioned caregiver—

the spouse. The Club emphasizes services to the families to help avoid this likelihood of failure. The services pertain to practical, real-life needs.

**Drugs**

In the Club's second year of operation, the spouses requested information on drug side effects. The Club responded by scheduling a speaker who discussed drugs used in stroke management and drug side effects in wives who felt an over-reliance on tranquilizers.

Apparently many spouses, particularly females in the 50-plus age group, had developed a dependence upon drugs. The spouses agreed that drugs were useful in moderation; they complained about tension, stress, and minimal ability to cope with their stroke afflicted partners. But, the spouses conceded, drugs were a poor substitute for problem solving.

**Aphasia**

Many stroke victims in the Club suffer speech and language dysfunctions. The veteran members of the Club benefit from speech-language therapy at the medical facility. The non-veterans can not obtain professional speech-language care so easily.

The absence of hospital-based speech-language clinicians leaves many aphasic non-veteran stroke victims without diagnostic speech-language tests to classify their communicative status by type or severity. The number of persons afflicted by cerebrovascular accidents which result in communication defects warrants the health community's attention to providing more accessible services in aphasia therapeutics.

**Conclusion**

Four years of exposure to the problems facing stroke families from midwestern Pennsylvania identify the limitations of acute care alone, regardless of its quality. Except in rare instances, stroke victims leave hospitals and special treatment facilities to return to the care of their families.

The physical, communicative and emotional changes imposed by cerebrovascular accidents limit the typical family's success in managing the stroke victim in the home. The families require training to equip them for the task of meeting the needs of the individual victim.

Establishing formal, comprehensive stroke recovery programs is long-term idealism. In the meantime, the realities of stroke management can be effected through stroke clubs. Stroke clubs like the one in midwestern Pennsylvania can be organized and operated inexpensively. The results will prove rewarding for families and clinicians alike. □


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# obituaries

• *Indicates membership in the Pennsylvania Society at time of death*

• **Jerome Robert Collier,** Northampton; Hahnemann Medical College, 1976; age 30, died December 21, 1979. Dr. Collier was on staff at Sacred Heart Hospital, Allentown, and received the 1979 Warner Chilcott Teacher Development Award.

• **Walter Bell Cope,** Indiana; University of Pittsburgh School of Medicine, 1929; age 75, died December 12, 1979. Dr. Cope was recognized in 1979 for 50 years of practice.

• **John Wood Gordon, Jr.,** San Diego, California; Jefferson Medical College, 1926; age 78, died November 1979.

• **Cornell G. Gray,** Hanover; Harvard Medical School, 1927; age 77, died December 21, 1979. Dr. Gray practiced in Hanover for 46 years.

• **Charles M. Hoffman,** Lancaster; University of Pennsylvania School of Medicine, 1941; age 64, died November 24, 1979. Dr. Hoffman, private practitioner in general medicine for more than 30 years, served as medical consultant to leading Lancaster industries.

• **Carl Ludwig Knopf,** Newtown Square; Jefferson Medical College, 1942; age 63, died December 17, 1979.

• **Jerome Jack Rubin,** Philadelphia; University of Pennsylvania School of Medicine, 1938; age 66, died December 18, 1979. Dr. Rubin was a retired police and fire surgeon.

• **Harry Alexander Smith,** Wilkes-Barre; Jefferson Medical College, 1915; age 93, died November 30, 1979. Dr. Smith was one of the founders of the Wyoming Valley Crippled Children's Association where he served as surgeon for 50 years. He formed the first orthopedic clinic at the Wilkes-Barre General Hospital in 1931. In 1971, he was honored as "Pennsylvania Physician of the Year" by the Governor's Committee on Employment of the Handicapped.

• **John Roy Wise,** Lebanon; Temple University School of Medicine, 1947, age 64, died December 26, 1979. Dr. Wise was a general practitioner in Lebanon for 31 years.

**William T. Foley,** Hershey; University of Cincinnati School of Medicine, 1968; age 38, died December 5, 1979. Dr. Foley was a staff anesthesiologist at Hershey Medical Center.

**Anthony Ralph Minadeo,** Erie; St. Louis University School of Medicine, 1936; age 67, died November 20, 1979. Dr. Minadeo practiced dermatology in Erie for 40 years.

**James V. Valerio,** Philadelphia; Jefferson Medical College, 1943; age 62, died December 2, 1979. Dr. Valerio had maintained a private practice in Overbrook for 25 years before joining the staff of the Sidney Hillman Medical Center in 1973.

**Howard S. VonUnangst,** Swarthmore; University of Pennsylvania School of Medicine, 1959; age 55, died December 17, 1979. Dr. VonUnangst had a general practice in Swarthmore.


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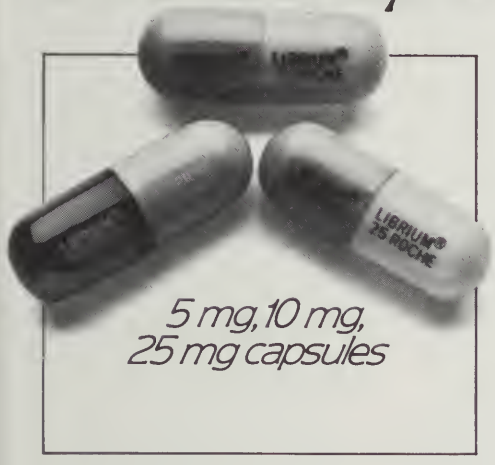


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**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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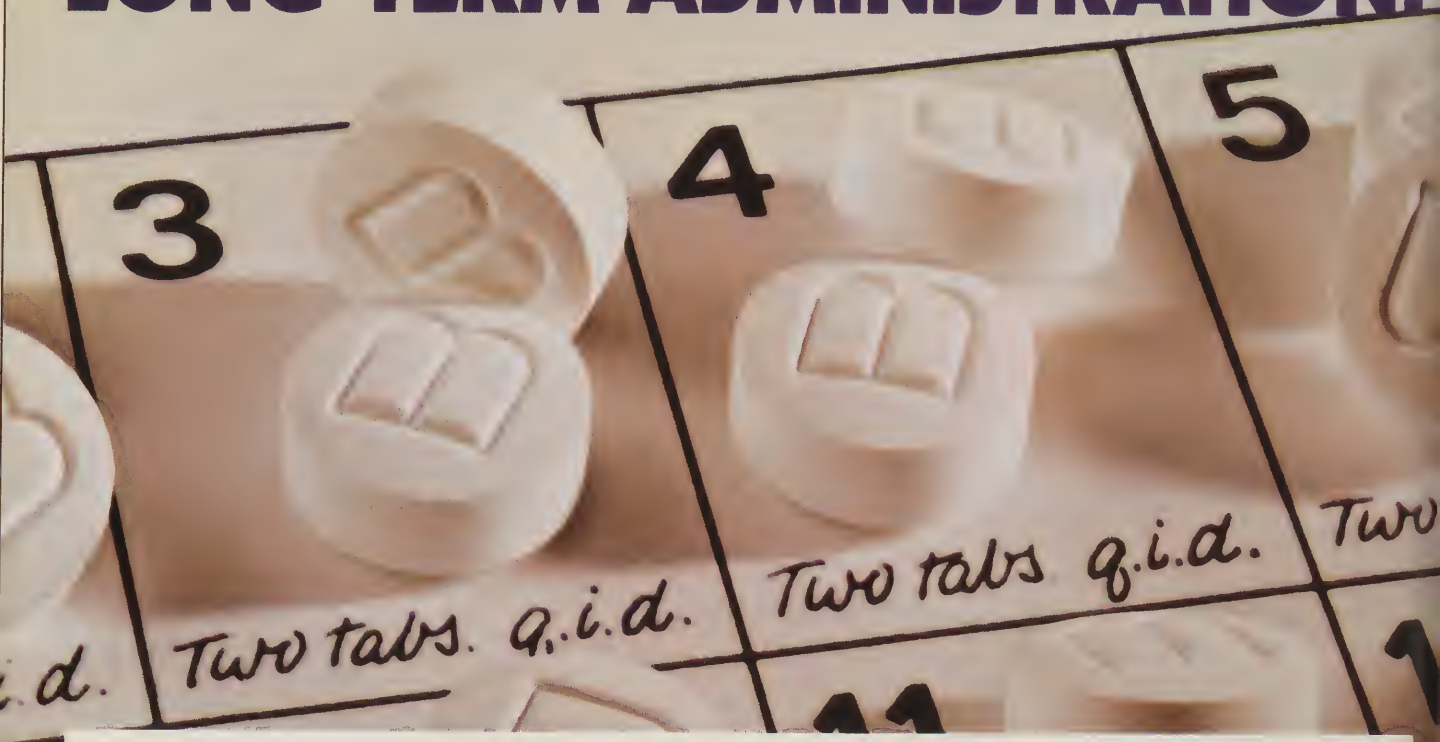

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## INCREASING MEDICAID FEES TOP PMS PRIORITY IN 1980

Improvements in the state's medical assistance program became a top priority for PMS in 1980 by vote of the Board of Trustees February 6. The Board pledged all resources of the Society to support the Council on Medical Economics in its efforts toward an increase in physician reimbursement for an office visit from the current $6.00.

Council Chairman John Helwig, Jr., MD appointed a Subcommittee on Medicaid to effect changes in the MA program, including the surgical and procedure fee schedule as well as the increase in office visit reimbursement. Members of the subcommittee are Drs. Lester A. Dunmire (chairman), John R. Paluso, Thomas P. Gessner, Robert S. Pressman, Walter M. Greissinger, Jan R. deVries, Peter V. Favini, and Walter P. Lomax, Jr.

The committee had an important agenda item for its first meeting on February 19. On February 5, in his budget message to the legislature, Governor Dick Thornburgh recommended an increase in fees for an office visit under medicaid from $6.00 to $8.00 and other changes to encourage outpatient care where indicated for patients on medical assistance.

## ARBITRATION FEE BILLING SET FOR END OF MARCH

The Office of Arbitration Panels for Health Care, which oversees panels hearing medical malpractice cases, has said it will send statements for the $25 annual assessment at the end of March. The arbitration system established by Act 111 is funded by the assessment.

## NEW SECRETARY OF HEALTH ATTENDS BOARD MEETING

H. Arnold Muller, MD, secretary of health, attended the February meeting of the PMS Board, the first held since his swearing in. He reported that the department is holding a series of planning meetings to establish priorities in the light of a no growth budget.

## BOARD OF TRUSTEES APPROVES PLANNING COMMITTEE PROJECT

The Society's Board approved February 6 a proposal for a Society Strategy/Planning Study, to be conducted in four phases by Hay Associates, Philadelphia. The purpose is to develop a yearly system of planning and review. The first phase includes interviews with the Society's officers, trustees, and council chairmen. A survey of the membership will follow. The study is expected to be completed by the June Board meeting.

## PMS BOARD APPROVES NEW CME FULFILLMENT

In an effort to reduce paperwork for physicians, the Board of Trustees in February approved another method of showing evidence of having fulfilled the CME requirement for PMS membership. Hospitals are fulfilling a JCAH requirement that staff privileges require continuing medical education. If a PMS member fulfills the requirement of the hospital for staff privileges, he meets the PMS education requirement, provided the hospital's requirement is equivalent to the PMS membership standard.

OFFICERS' CONFERENCE OPEN TO MEDICAL STAFF PRESIDENTS

Presidents of the medical staffs of some 350 Pennsylvania hospitals have been invited to attend the 1980 PMS Officers Conference as guests of the Society. The Board of Trustees on February 6 allocated funds to extend the invitation on the recommendation of the 1980 Officers' Conference Committee. David L. Miller, MD, committee chairman, said the 1980 program features several topics of special interest to this group of physicians. Further details on the conference appear on page 8 of this issue.

SOCIETY CONTRIBUTES $1,000 TO DR. GLOECKNER TRUST

The Pennsylvania Medical Society has contributed $1,000 to The M. Louise Carpenter Gloeckner Memorial Trust of the College of Physicians of Philadelphia. The trust was established in 1979 to memorialize Dr. Gloeckner, the first woman to serve as an officer of the AMA and a leader of organized medicine at all levels. George P. Rosemond, MD, president of the College of Physicians of Philadelphia, announced that the trust would assure the continued publication of Transactions & Studies, the college's journal and the oldest medical journal continuously published in the United States. Tax deductible contributions may be sent to the college, 19 South 22nd St., Philadelphia, 19103. Checks should be payable to the M. Louise Carpenter Gloeckner Trust.

MEASLES IN PENNSYLVANIA ALREADY OVER 1979 TOTAL

H. Arnold Muller, MD, secretary of health, said February 8 that about one-fourth of Pennsylvania's school age children may be at risk of contracting measles, regardless of past immunization history. Since January 1, 56 cases of measles have been reported. The grand total for 1979 was 47 cases. The health department is "strongly urging" children immunized before 1968 or before they reached 12 months of age to seek re-immunization. The cases reported so far have appeared in Montgomery and Northumberland counties, except for five in Blair County and two in Columbia County. Most of the group at risk are in the junior high school grades and 12 to 15 years old.

SUPREME COURT UPHOLDS HEALTH DEPARTMENT RULES

The Pennsylvania Supreme Court on February 1 issued a decision upholding Department of Health regulations governing general and special hospitals. Published in December, 1977, the regulations were developed over a five-year period. Portions dealing with hospital administration, prerogatives of hospitals' boards of trustees, and a patients' bill of rights were contested by the Hospital Association of Pennsylvania, which appealed to Commonwealth Court and then to the Supreme Court. The decision lifts an injunction on enforcing the rules granted in May 1979 until the Court reached a decision. Implementation will be delayed to allow time for compliance and for coordination of the health department's inspection with that of the Joint Commission on Accreditation of Hospitals.

Pennsylvania Medicine

Pennsylvania Medicine

POLICY STATEMENT

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Carol N. Maurer, MD, Chairman, Oil City
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**STAFF**
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Medical Editor
Mary L. Uehlein,
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KathyLee Santangelo
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[1] Tinkelman, D.G., Carroll, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. Medical Challenge 10:24-26, 1978.

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# editorial

## Reawakening 'new' ideas in medical education

In 1970, the American Medical Association adopted the stance that the internship program should be related to residency programs and conducted as a unified whole. The members agreed that the first postgraduate year would be integrated into residency and, for practical purposes, the rotating internship would cease to exist.

With the beginning of the 1980s, delegates to the American Medical Association meeting are moving cautiously toward the concept of a "comprehensive residency." This program, it is hoped, would provide the means to experience broad coverage of the major clinical services rather than the fragmented, narrow experience offered by the specialty and subspecialty residency.

Ideally, the "comprehensive residency" should be conducted as a free-standing program, not as a part of an existing residency program. Samuel Johnson is purported to have said, "New things are made familiar, and familiar things are made new." The comprehensive residency is a familiar thing made new.

The question that immediately occurs is why is it necessary to return to a broad medical experience in the first postgraduate year. In the past decade, a number of discoveries surfaced which emphasized the importance of medicine as a learned profession. It was 'discovered,' for example, that physicians need a broad basic education to develop attitudes, knowledge, and skills necessary to interact with patients in their care. At the same time, it was 'discovered' that the art of medicine is more than a body of scientific facts, memorized and categorized, in a doctor's mind. "Science is impersonal; art is intensely personal. . . . The essence of the art of medicine is the relationship between the doctor and the patient." (Sir George Pickering, *Acta Medica Scandinavica 204:* 339, 1978.)

A broad clinical experience is necessary in dealing with patients as people, as living, feeling individuals rather than disease entities. Specialization focuses on specifics, organs, diseases, organisms, and tends to dismiss personalities, people, and generalities.

The humanities are being reemphasized in medical education. It was 'discovered' that a medical education required experience in areas other than advanced science and technology. Although physicians need to be skilled in interpreting the vast amounts of data that are generated by modern technology, they also need exposure to the humanities and to other intellectual pursuits. K. Danner Clouser, PhD, professor of humanities at the Milton S. Hershey Medical Center wrote, "Useful interdisciplinary scholarship grows from immersion at the interface — from helping, teaching, interacting and listening." (*Journal of Medical Education 52:* 930, November 1977.) This integral part of medical education and medical practice is not an innovation of the decade of the 1970s. In 1897, Sir William Osler expressed this concern: "By the neglect of the study of humanities, which has been far too general, the profession loses a very precious quality."

Regardless of the changes recommended, the normal maturation process of the individual has to be able to occur at a rate tolerable to that individual. Not all physicians possess the same qualifications or background nor can they achieve the same standards from their respective educations. What is important is that the tools by which the best physicians may be developed are available so that the most beneficial results will accrue to our society. The comprehensive residency seems to have a good chance of success as measured by these ideals.

Hans Zinsser, 1878-1940, professor of bacteriology at Columbia University wrote, "We have been living in an era of science. And it is not unnatural that our university administrators should have given the scientific departments a disproportionate degree of encouragement and support to the neglect of the humanities. Yet there are growing indications that the tide is turning: and men in leading positions are beginning to realize that the backbone of intellectual training lies in liberal education and in the adjustment of the content of the humanities to modern conditions." The art of medicine will be preserved in the reawakening of these "new" ideas.

David A. Smith, MD
Medical Editor

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# newsfronts

## Current issues in focus for Officers' Conference

**KathyLee Santangelo**

Muhammad Ali's doctor, a physician Congressman, and a political forecaster will address participants of the State Society's 1980 Officers' Conference April 23 and 24 at the Penn Harris Motor Inn, Camp Hill.

"You are the champion" or so Dr. Ferdie Pacheco will tell you at the banquet Wednesday evening. Dr. Pacheco is known as the "Fight Doctor" from the book he authored on his experiences as Muhammad Ali's physician.

Dr. Pacheco graduated from the University of Miami Medical School in 1954 and interned at Mt. Sinai Hospital, Miami Beach. In 1959 he began general practice in the ghettos of Cuba.

Before long Dr. Pacheco combined his medical career with his second love, boxing. He worked in the corners of ten world champions and uses his own gloves of wit and humor to fight for causes and to conquer his audiences.

Dr. Pacheco is jazz connoisseur, sports figure, writer, painter, and storyteller. His cartoons and caricatures have been published, and he has produced lithographic prints. He is the author of many books including *Fight Doctor, Sweet Sam and the Doctor Man,* and *Tales of Fifth Street Gym.*

On Thursday, Tim Lee Carter, MD, one of two physician members of Congress, will deliver the Walter F. Donaldson Memorial Lecture.

Dr. Carter's political career began before he entered medical school. On the precinct level he was county chairman for 12 years. He was active in district politics but did not hold a district office until his election to Congress in 1964.

Dr. Carter voices stern admonitions to fellow physicians. Only by taking an active role in politics, the Congressman says, can medical professionals control their own destinies and deal with the control proposals being advocated which pose potential threats to medicine.

DR. CARTER

Political forecaster Kevin Phillips will speak on "The 1980 Elections: The Stakes and the Probabilities." He is a syndicated newspaper columnist with King Features.

Phillips, a 1964 Harvard Law School graduate, is editor and publisher of the *American Political Report* and *Business Affairs Fortnightly.* President of the American Political Research Corporation, Phillips also authored *The Emerging Republican Majority, Electoral Reform and Voter Participation,* and *Mediocracy: American Parties and Politics in the Communications Age.*

Hoyt D. Gardner, MD, president of the AMA, will verbalize the AMA's concerns on current issues. Dr. Gardner has a private practice in general surgery in Louisville, Kentucky.

In 1970, Dr. Gardner was chairman of the Board of Trustees at the University of Louisville. Presently he serves as clinical professor of surgery there.

On the state level, participants will hear updates on health issues from Helen O'Bannon, secretary of public welfare, and H. Arnold Muller, MD, secretary of health.

The conference also will feature a panel discussion on who has the influence and power in a hospital. Entitled "A Question of Omnipotence," the panel will be moderated by Paul F. Kase, MD, chairman of the PMS Council on Health Planning and Facilities.

Participating panelists include Joseph N. Demko, MD, president of the medical staff at Community Medical Center, Scranton; Bernard Schmidt, chairman of the board of trustees at Harrisburg Hospital; and Albert W. Speth, administrator of Lock Haven Hospital.

In another session, physicians will be tested on their knowledge of medical staff bylaws. The quiz session, "What's your medical staff bylaws IQ?" will be conducted by Fred Speaker, the Society's legal counsel. Mr. Speaker will provide the answers to the quiz and to any other questions that participants pose.

Members of the 1980 Officers' Conference Committee are Drs. David L. Miller, chairman; Joseph M. Stowell, board representative, John H. Boal; Paul F. Kase; William D. Lamberton; Matthew Marshall, Jr.; and Wallace G. McCune.

### State reschedules drugs

Controls on five prescription drugs were tightened by the state health department.

Talwin, Darvon, Verstran, and Ativan were changed to schedule 4 drugs making their illegal sale a felony punishable by up to three years in prison and a $10,000 fine.

Imodium, because of its lower abuse potential, was placed on schedule 5. Illegal sale of Imodium is a misdemeanor punishable by up to one year in prison and a $5,000 fine.

The new controls were official with the publication of regulations in the *Pennsylvania Bulletin,* January 19.

Jack Ogun, director of the health department's Division of Drugs, Devices, and Cosmetics, said the action responds to the trend in society toward quick relief and instant cures.

Ogun added, "The patient suffering from stress is frequently handed a prescription for a tranquilizer instead of being helped to cope with that stress."

POLICY STATEMENT

# The relationship of physicians with non-physician health personnel

The 1979 House of Delegates adopted this policy statement prepared by the PMS Council on Education and Science. The House concurred that future relationships between physicians and non-physician health care practitioners may benefit from the clarifications expressed in this statement.

The Pennsylvania Medical Society adopted the following guidelines, for use by all members and by specialty societies, that define clearly a physician's relationship with non-physician health care practitioners. The purpose of these guidelines is to delineate the three-part relationship that exists in some aspects of health care, that relationship involving the physician, the non-physician health care practitioner, and the patient.

**Definitions**

In the course of their practices, physicians may have occasion to relate to various non-physician health care practitioners. In Pennsylvania, in addition to the state licensing boards for MDs and DOs, nine other health care boards regulate health care practitioners: nurses, dentists, optometrists, podiatrists, pharmacists, chiropractors, physical therapists, psychologists, and veterinarians. Also, there are various non-physician health care practitioners who may be certified by existing state agencies or by national organizations such as physician assistants, nurse practitioners, and emergency medical technicians. In the recent past allied health occupations have proliferated. Physicians must interact in various ways with these practitioners in the course of their practices.

**Responsibility to patient**

1. Every patient entering the health care system should be examined and diagnosed by a physician or physician designate who then recommends and supervises an individual treatment plan.

2. Hospitals, clinics, and physicians' offices should be organized so that each patient receives ongoing medical care according to an individualized treatment plan supervised by a physician.

3. Medications and various other therapies should be prescribed only by a licensed physician for patients he or his physician designate has seen.

4. The physician has primary responsibility for following those patients in his charge or under his supervision.

5. In all health facilities, the ultimate responsibility for patient care rests with the physician in charge.

**Types of relationships**

1. *A supervisory relationship* exists between a physician and a non-physician health care practitioner when the physician is in a position to manage directly and personally the process of examination, diagnosis, patient treatment, and care. The physician is responsible medically and ethically for the patient's care as long as the prescribed treatment continues under his supervision. Services provided by a non-physician health care practitioner under the direction and supervision of a physician are also to be considered medical services. Fees charged for these services should reflect accurately the various types and levels of care.

2. *A collaborative relationship* exists when the physician and the non-physician health care practitioner provide different but complementary functions relating to the patient's care or physical condition.

3. *A consultative relationship* between a physician and non-physician health care practitioner exists when the physician, upon request, provides professional advice or opinion regarding the patient's treatment or care on a one-time, periodic, or ongoing basis. The physician is responsible medically and ethically for his role in the consulted area; however, he is not responsible for the non-physician health care practitioner's actions.

Regardless of the type of relationship, the physician must be prepared to assure a correct diagnosis for the condition being treated. The physician also should satisfy himself that the competence of the non-physician health care practitioner is sufficient to provide the treatment indicated and delivered. The physician must be able to provide periodic evaluation of the patient's condition through personal examination so that a revision or continuation or termination, as indicated, of the patient's treatment plan may be approved.

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or which tend to cause a deterioration of the quality of medical care. When the physician assumes a supervisory or collaborative role with a non-physician health care practitioner, the physician must expend sufficient time to assure that proper medical care is given. It is contrary to the interests of the patient for the physician to allow himself to be used as a figurehead. In the delineation of the three types of relationships between physicians and non-physician health care practitioners, the physician should recognize the difference between (1) a physician initiating and carrying through a treatment plan, and (2) a non-physician health care practitioner initiating and carrying through a treatment plan.

# Malpractice liability case results from suicide attempt

**Fred Speaker, Esq.**

Failure to prevent a suicide attempt may bring malpractice liability. In a case[1] brought in a county court it was decided that the Health Care Services Malpractice Act[2] (Act 111) required that such a claim first must be arbitrated.

The case involved a patient who was confined in the hospital's psychiatric ward after a previous suicide attempt. The patient pried open a window, lowered knotted sheets, climbed out, and fell from the fifth floor when the sheets ripped.

The patient suffered severe injuries and later sued to recover damages sustained because of the hospital's failure to confine the patient in a secure place and for having easily removable windows.

The court agreed with the hospital's contention that it had no jurisdiction since the case first must be arbitrated under Act 111. The court also discounted the patient's contention that his claim was not based on "the furnishing of medical services" as provided by the statute.[3] The court said:

> Certainly not all negligence claims against a hospital should be directed to the arbitration panels. For example, the act might be considered inapplicable to a suit brought by a visitor to a hospital who slipped and fell in a newly-waxed corridor. But the alleged negligence in this case is not merely a product of the upkeep of the building. Plaintiff, in his cause of action, raises questions concerning the hospital psychiatric ward's supervision and restraint of a person with known suicidal tendencies. The supervision of such a person is a subject intimately related to the treatment being received. . . . Plaintiff was in the hospital because of his self-destructive behavior. Any treatment of this mental illness would necessarily be concerned with the types of restraints placed upon the patient and the supervision exercised by the hospital. Here, where the aim of the treatment was to repress plaintiff's self-destructive impulses, the type of confinement prescribed for him is considered as being part of the furnished medical services.
>
> Viewing the totality of the circumstances of this somewhat unusual factual situation we conclude that the legislature did intend that a case such as this should first be heard by an arbitration panel before court proceeding can be initiated.[4]

Although this case did not involve a physician, physicians should be interested for several reasons: a similar case could be brought against physicians; there is potential liability; and apparently a similar case would fall within a physician's medical malpractice insurance coverage.

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*

1./ *Herr v. St. Francis Hospital of New Castle*, 9 D&C 3d 610 (lawrence 1978).
2./ 40 P.S. §§1301.101 *et seq.*
3./ 40 P.S. §1301.309.
4./ *Herr v. St. Francis Hospital of New Castle, supra* at 612-13.

## Two counties hear health secretary

**Dr. Blacksmith (far left) hosts special guests Drs. Muller, Grandon, and Danyo (left to right) at Cumberland County annual meeting.**

H. Arnold Muller, MD, state secretary of health, spoke to members of Cumberland and Franklin County Medical Societies in January.

On the occasion of its annual meeting, Cumberland County hosted Dr. Muller whose comments focused on the private physician in the Commonwealth. The county also hosted Richard O. Stader, MD, president of Franklin County Medical Society and many of its members.

Special guests who attended the meeting included Raymond C. Grandon, MD, PMS vice president and John J. Danyo, MD, Fifth District trustee.

New officers of the Cumberland County society are Drs. Gary L. Blacksmith, president; J. Craig Jurgensen, president elect; Rodney K. Hough, vice president; and Herbert C. Perlman, secretary treasurer.

## Surgeons produce public health spot announcements

The American College of Surgeons has produced three 60-second public service announcements to be released this year to cover 600 commercial television stations nationwide. The public health education effort is a project of the ACS Communications Department.

Two of the announcements, "Chain Saw Safety" and "Cycling Safety," describe precautions needed to avoid injury and possible surgical intervention caused by accidents. The third, "Before Surgery," encourages surgical patients to recognize the importance of understanding their operations and to discuss their operations with their surgeons.

These three announcements supplement the six public service announcements that ACS has produced since 1977. An audience of about 625 million viewers has seen the spots on child surgery, and diving, motorcycling, skiing, and skateboard safety and another 250 to 300 million viewers are expected to see the spots.

# Pediatricians continue to speak for children

Children who traditionally have been seen and not heard now have a voice speaking on behalf of their welfare. The American Academy of Pediatrics (AAP) is verbalizing the issues in child health through its Speak Up for Children campaign.

Begun as a project for the International Year of the Child, the campaign's goals span four areas of concern: accident prevention, nutrition, immunization, and health education. Susan S. Aronson, MD, is project director for the Pennsylvania Chapter of AAP's Speak Up for Children.

**Accident prevention**

Most of the efforts in accident prevention have been directed toward motor vehicle safety.

The Governors Traffic Safety Council is contributing to the campaign with its statewide child restraint public education program. The council also is promoting the use of seatbelts in the four county area of York, Cumberland, Dauphin, and Lancaster as a test market before the program is launched statewide.

**Nutrition**

The Child Health Planning Committee has recommended changes in the curricula of physician training programs. The Committee mailed letters to the directors of these programs and urged them to emphasize breast feeding, prevention of iron deficiency anemia, and supplementation with fluoride in the programs involving physicians who see children and infants.

The Women's, Infant's, and Children's, (feeding) Program of the state continues to reach the public. Studies indicate the participating infants have increased height, weight, and head circumferences; better height and weight gains; and fewer growth abnormalities than in similar nonparticipating children.

**Immunization**

Health professionals in Pennsylvania accomplished protection of a greater percentage of children than in other states. Results of the school immunization program indicate that the percent protection varies from a low of 88.8 against rubella to a high of 95.4 against poliomyelitis.

The immunization survey of day care facilities revealed that 47.2 percent of 15 to 23 month old children were up-to-date with their immunizations. As a result of the survey, the departments of health and public welfare will implement an immunization program for day care providers. The public welfare departments also will review immunization complaints as part of its annual licensing procedures.

The Pennsylvania Chapter of AAP supported House Bill 1720, which would require children who are not fully immunized before entry to school to begin an immunization plan within two weeks. Should the child's plan be delayed or postponed for more than 30 days, the parents will be fined and the child will be excluded from school. The bill passed the House and is in the Senate Health and Welfare Committee.

Upon the recommendation of Speak Up For Children, mumps vaccination was included as a mandatory school entry requirement effective in Pennsylvania on August 1, 1980.

**Conclusion**

Private practicing physicians have joined the campaign through sponsoring such events as walk-a-thons for the International Year of the Child and patient photo contests. Donations raised at these events are going to UNICEF.

The Speak Up For Children program will expand in 1980 when the American Academy of Pediatrics will address six other national health goals. According to the national AAP, Speak Up For Children has been so successful that it will be continued as an ongoing activity. Physicians interested in the program should contact David Blunk, Department for Specialty Societies, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043.

## State ends policy of supplying globulin

Immune serum globulin will not be available from state health centers once the current supply is exhausted.

Mary Ann McCarthy, RN, of the Division of Epidemiology, Pennsylvania Department of Health, said that the department's policy had been to provide Immune Serum Globulin (ISG) to private physicians and hospitals for administration to indigent people who have close contact with Hepatitis A.

Local state health centers will continue this policy until the current supply of ISG is exhausted, at which time the program will be discontinued.

ISG's easy commercial access and relatively low cost prompted the decision to discontinue supplying it through the department.

## PAOO Bedford meeting studies pharmacology

The Pennsylvania Academy of Ophthalmology and Otolaryngology will highlight an in depth study of pharmacology at its 36th Annual Meeting May 21-24 at Bedford Springs Hotel, Bedford, Pennsylvania.

All physicians are invited to the balanced program of scientific sessions, instructional courses, symposia, residents' presentations, and surgical videotapes. Physicians who attend the scientific program qualify for 15 Category I AMA credit hours.

Eugene B. Rex, MD, Philadelphia otolaryngologist, will become immediate past president of the academy as Jerome Dersh, MD, Reading ophthalmologist, is installed as 1980-81 president.

The academy will host Charles M. Norris, MD, professor and chairman of the department of laryngology and bronchoesophagology at Temple University School of Medicine.

Thursday's opening joint session will feature the Paul Craig Symposium on "What's new in E.E.N.T. pharmacology." The scientific session of the ophthalmology program will include symposia on visual loss and trauma. Otolaryngology scientific sessions will focus on ear, nose and throat disorders of children.

# in my opinion

## PAC support essential

*Reprinted from the Allegheny County Medical Society* Bulletin, *November 10, 1979.*

Over the past 15 years the impact of governmental rules and regulations has significantly altered the practice of medicine in our country. This alteration on the whole has not worked to the benefit of the American public. Witness the heavy handed regulation of the Federal Trade Commission regarding advertising in medicine vis-a-vis the gross distortion of "cosmetic surgery" as practiced by some charlatans in the Southern California area. This government involvement is a consequence of the "liberal" bent of government activity during the last two decades.

There is evidence, however, that the mood of the electorate is changing, and that Americans are no longer enamored of the "liberal" solutions to problems, with increasing governmental intrusion into their private lives. This change has been reflected in recent voting patterns. Over 50 percent of representatives currently serving in Congress have served for two terms or less and their voting patterns have become more conservative, in response to the mood of the public. In addition, the great increase in the number of political action committees, from a handful to over 1,850 in the past four years, has provided another important vehicle for citizen participation.

Physicians also have become more involved in the political process, as well they should. Each year for the past nine years membership in the American Medical Political Action Committee (AMPAC) has set new records. Currently, about 70,000 American physicians are members. Yet their average contribution to this important activity is $11.50. Contrast this figure with the $120 per year "voluntarily" contributed to political activity by members of the plumbers union in Philadelphia. Or consider the average contribution of Pennsylvania chiropractors, which is $500. It should not be surprising that these groups are quite effective in their lobbying efforts.

Physicians who are not members of the Pennsylvania Medical Political Action Committee should ask themselves, "What is it worth to continue the private practice of medicine in a democracy?" By joining AMPAC and PaMPAC, all of you can improve that disappointing figure, and answer the question—

"How much is it worth?"

Michael P. Levis, MD
AMPAC Board Chairman

## PMS road signs

Many of you can remember the Burma Shave road signs. A series of six small signs was placed along the roadside one hundred paces apart. They had a jingle cadence and a folk humor that had great appeal.

Driving along at 35 miles an hour (a reasonable speed in the 20s and 30s), you would proceed from sign to sign in about three seconds and pass by the whole series in eighteen seconds. The last sign always said, "Burma Shave." Over the years they sold a lot of shaving cream.

Now, since the medical profession is under considerable pressure to advertise, it occurred to me that maybe the PMS could rejuvenate this six-road-sign idea and come up with some ads like the following:

*Eeny Meeny*
*Miney mo*
*Save your health*
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*PMS*

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*Do your part*
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J. Mostyn Davis, MD
Shamokin

## What's your "C.Q.," Doctor?

*Reprinted from the Allegheny County Medical Society* Bulletin, *October 31, 1979.*

Find a quiet corner in the doctors' lounge and take the following quiz. You can do so with impunity: you need not report your score, and it will not count against your continuing medical education credits. But your performance will give you a clue as to how knowledgeable you are about health care costs . . . your C.Q., or "cost quotient," as it were. (And it might prompt you to ask some questions of your own in the administrator's office or at the next board meeting.)

1. What is the current Blue Cross per diem reimbursement rate at each hospital to which you admit patients? What is its annual rate of increase? At that rate, what will be the per diem rate in a decade?

2. What is the **cost** of each test you routinely order for your hospitalized patients? What is the **charge** for those procedures billed to self-pay or privately insured patients?

3. How much will the pharmacist charge your patient for the medication you prescribed on his last office visit? How much would he (or his insuror) be billed for that same prescription if you had ordered it for him as an inpatient?

4. What was the total hospital bill for the last patient you discharged?

5. What is the proposed purchase price (or construction cost) of the latest project your hospital submitted for Health Systems Agency review? What will be its long-term cost (including debt service and depreciation)? Its annual

operating cost? How much will it increase the hospital per diem rate? Will its utilization address patient — or amortization — needs?

You will find some of the answers in the Urban League of Pittsburgh's latest Community Report, *The Cost of Staying Alive,* a profile of "where the money comes from and where it goes" in local hospitals. From it you also will learn the relative financial health of these institutions, their current and projected daily rates, and the top salaries and fees they pay for professional services.

Why should we bother with such mundane matters? Why should we — whose fees account for only 20 cents of the health care dollar — concern ourselves with the details of the crisis in health care costs?

There are two compelling reasons why we, as physicians, should assume a share of the responsibility both for the escalation of costs and for the solution to a problem which, indeed, is approaching crisis proportions.

First of all, we have — like it or not — a major responsibility for the nation's $230 billion health bill. We collect only about one-fifth of it, but our decisions determine how a staggering 70 percent of it is spent. We order the tests, prescribe the medication, recommend the surgery, engage the consultants, and determine when, where, and for how long patients should be hospitalized.

The irony of it all is that most of us — who can quote the current price per gallon of gasoline at the corner service station — have only the vaguest notion of how much the diagnostic tests (or the medication) we prescribe actually cost. Most of us do not really know how much we are adding to a patient's bill when, pressed for time or by the patient's family, we authorize an extra day in the hospital.

The fact is that, with current Pittsburgh per diem rates approaching $200 a day, the community's health care bill would increase by about one million dollars if each member of the county medical society were responsible for only two unnecessary days of hospitalization per year. If the average hospital bill is $1,200 (a modest estimate) and we each admit one patient needlessly, we inflate local health care costs by $2.5 million annually.

But there is a second, more compelling reason why we should begin to take this cost problem seriously. We are not only helping to push up the bill; we are paying it as well — and our Blue Cross premiums are just the tip of the iceberg.

The window stickers on the new cars we buy do not list the cost of health insurance premiums the manufacturer pays for its employees, but that adds $150 to $200 to the purchase price of each automobile. (And the same is true of virtually every other item of consumer goods we purchase.)

We are paying medicaid and medicare premiums for millions of Americans through our tax dollars, but we are paying even more to make up for the revenue lost through untaxed health insurance premiums and hospital real estate, through tax-free revenue bonds which finance most new construction, through individual deductions for excess medical costs, and for philanthropic gifts. We are subsidizing, through personal income tax, the tax-free status of the institutions where we practice and the insuror who pays most of our fees.

Out of self-interest, pure and simple, if not for reasons of community responsibility or concern for those patients who, before long, may find themselves priced out of the health care market, we need to take a more active role in the business of cost containment. Urban League Executive Director Arthur J. Edmunds, a veteran board member of Hospital Council and of a local teaching hospital, states in the preface to the League report, ". . . this problem is too great and too important to be left to the professionals (*i.e.,* planners and administrators). It can be solved only through the joint efforts of those whom it affects and that is all of us."

Those of us whose "C.Q." (as measured by the quiz above) is deficient should make health care costs a part of our continuing education, and *The Cost of Staying Alive* is a good place to start. (Request a copy from the Pittsburgh Urban League, (412) 261-6010 — and when you have read it, pass it along to a colleague or leave it in the doctors' lounge for others to read.)

The League report, cited by Phil Donahue on the NBC "Today" Show, and adopted as a supplementary text in a state college, presents some eye-opening statistics. But, more important, it makes a strong case, explicitly and implicitly, for full disclosure of all financial and utilization data by "these public institutions which too often behave like private businesses." This point was underscored by former state health secretary Gordon MacLeod's recent call for an amendment to the new licensure bill which would mandate such disclosure for all licensed facilities.

It is time for us, as physicians (who are expected to have all the answers) to begin asking the questions—of administrators, boards, and planners. We are, obviously, part of the problem; it is time for us to become, instead, part of the solution.

Marshall M. Johnson, Jr., MD
Pittsburgh

## Positive critique of public welfare

*Excerpted from a personal communication to Helen O'Bannon, secretary of public welfare, December 4, 1979.*

Your presentation to the Allegheny County Medical Society last fall was interesting and encouraging. However, you have to understand that only 15 to 18 percent of all physicians in Allegheny County are willing to see welfare patients due to the reasons I have discussed many times.

It is of great concern that state and local welfare medical advisory boards are being established with institutional physicians or physicians who do not accept DPA patients rather than with those who actively participate in the program.

According to your statement, our commonwealth is still under the Consent Degree for EPSDT. The program was very successful here in Western Pennsylvania; as a matter of fact, it was a model for the nation (see presentation at the APHA 1977 in Washington, D.C.).

Last year your department decided to discontinue its outreach contract with HSRF in Allegheny County and let the local board handle that phase of the program. Even though the local board is quite willing to do the job, it has not been able to do so due to personnel problems. As a result, we most probably will again come under attack from the courts as not fulfilling the Consent Degree and at the end of the year we have "to play a numbers game" which is, of course, very detrimental to the excellent quality we had in the program.

The state medical advisory board to EPSDT has not met for over one year and there are many problems which need medical discussion, solutions, and advice. If I understood your remarks, you will convene that board in the near future.

For several years now, the welfare department has worked on the MAMIS Program. You inherited that program. It was conceived by computer people without initial consultation by providers. As it was presented to us almost two years ago, the forms were totally impractical and unworkable for an active private practice.

It now has come to our attention that MAMIS will be pushed on physicians in 1980. It is expected to cost your department about $15 million annually, and one to several dollars to process a form. With a six dollar reimbursement to the private providers for care, what value do you place on the care of the poor in Pennsylvania?

The issues are many. It is not that there aren't enough physicians who would like to participate in the care of the indigent of our commonwealth but we feel that we are taken advantage of by our peers who refuse to see DPA patients, by the organized health care system, and by your department, which is responsible for the supervision of health care for the poor.

We know how to deliver the best health care to our people but we need your cooperation and help.

I hope you will accept this letter as a positive criticism of the Department of Public Welfare. Jointly, your staff and ours can make it the best system in the United States.

Walter M. Greissinger, MD
Pittsburgh


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Case report

# Sarcoma botryoides—twenty-five year survival

Joseph A. Hepp, MD

Sarcoma botryoides is the most common malignant tumor of the lower genital tract in children.[1] Ninety-nine years ago Spiegelberg described it as "sarcoma colli uteri hydropicum papillae."[2]

Previous authors have reported survivals of 10, 12, and 20 years.[3-5] El-Mahdi reported a twenty-five-year survival of sarcoma botryoides treated by irradiation.[6] Simpson reported that this tumor appears to arise in the cervix uteri chiefly during the years of active reproductive life in contrast to origin in the vagina during infancy or childhood.[7]

A few cases of treated vaginal sarcoma botryoides in which the patient survived have been reported in the older literature. Volkmann excised a vaginal sarcoma botryoides in a two and one-half year old child. The lesion recurred, was excised again, and the child was alive without recurrence 10 years later.[3]

In 1954 Laufe and Meyers reported on mixed mesodermal tumors of the uterus.[8] They included a case report of sarcoma botryoides which was treated by local excision. This report presents a follow up of that patient. She is well with no evidence of disease 25 years after excision of the cervical polyp, D and C, and cautery to the area of attachment of the polyp to the cervix.

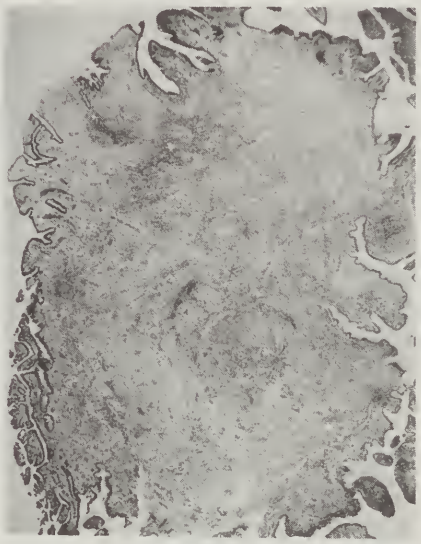

*Figure 1.* Sarcoma botryoides — cross section of cervical polyp (x25).

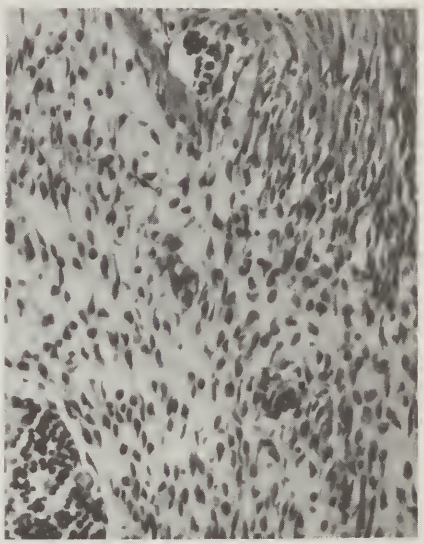

*Figure 2.* Sarcoma botryoides — tumor cells among round and spindle cells (x250).

## Case report

In 1953, a 14-year-old patient was admitted to Magee-Womens Hospital because of spotting and a protruding vaginal mass. There had been spotting of blood between menses for two months prior to admission. The patient said she noted "a cluster" protruding from the vagina. Menarche was at age 12 with irregular menses for one year followed by regular menstrual periods every 28 days thereafter.

Pelvic examination revealed normal external genitalia and intact hymen. There was a polypoid mass 3 cm x 2 cm protruding from the cervical canal on a pedicle. The uterus and adnexa were normal. There was no palpable enlargement of inguinal lymph nodes.

Polypectomy and D and C were performed. The polyp was read as sarcoma botryoides. The curettings showed hyperplasia of the endometrium. Emil Novak[9] and Arthur T. Hertig[10] diagnosed the tissue as sarcoma botryoides.

Dr. Hertig commented: "I am impressed by the loose mesenchymal architecture of this cervical polyp and the fact that it is sometimes in juxtaposition to Müllerian epithelium—the so-called cambrium layer from which it is believed sarcoma botryoides arises. There is nuclear pleomorphism. The presence of mitoses in the mesenchyme and in the adjacent smooth muscle convinces me that this is a neoplasm, also there appear to be transitions between the smooth muscle and the mesenchyme. I am convinced this patient has an early sarcoma botryoides."

This patient has been followed regularly and Pap. smears have been negative for neoplastic cells. At age 26 she delivered a normal full term male, and at age 29 she delivered a second normal full term male.

At age 32 a vaginal hysterectomy was performed for menometrorrhagia. The pathologist reported leiomyomata uteri, secretory endometrium, and chronic endocervicitis. Careful study of the uterus and cervix revealed no evidence of malignant neoplasm. The patient is now 39 years old and healthy.

## Discussion

Despite some controversy, today

*Dr. Hepp is director of the Tumor Registry at Magee-Womens Hospital, clinical professor emeritus in gynecology and obstetrics at University of Pittsburgh School of Medicine, and senior consultant in gynecology at St. Francis General and Magee-Womens hospitals, Pittsburgh.* *Dr. Hepp acknowledges the assistance of Mrs. Vida Peterson and the personnel of the Tumor Registry.*

treatment of this neoplasm consists of radical surgery,[11] irradiation,[6] and a combination of chemotherapeutic agents such as vincristine, cytoxan, and actinomycin-D.

Review of the literature reveals broad disagreement as to classification and nomenclature of this tumor. In the older literature this tumor has been given no less than 119 different names.[12]

Exelby describes sarcoma botryoides as a type of embryonal rhabdomyosarcoma.[13] Others include this tumor in the class of mixed mesodermal neoplasms.[8,14] Still other terms encountered include a subgroup of rhabdomyosarcoma,[15] and embryonal rhabdomyosarcoma-botryoid type,[16] or botryoid rhabdomyosarcoma.

In spite of these differences in the name of this tumor, there is agreement that it is a malignant tumor. The differences in names of this tumor are expressions of its various pathological interpretations.

Microscopically the tumor we are reporting showed no cross striations in the muscle and no heterologous mesenchymal elements. E. R. Novak[2] and Robboy[17] state that heterologous elements such as bone and cartilage are not necessary for a diagnosis of sarcoma botryoides.

Two cases reported by Dunster,[15] each appeared as a single cervial polyp; both patients were treated by surgery and both are living and well ten years and seven years later respectively. Hertig and Gore noted that some patients with early disease have been cured by less radical surgery.[18] In this case, we excised the polyp and cauterized the site of origin in the cervix.

## Summary

Apparently this patient received treatment when the tumor was localized. In this case, as is common in oncology, the nature of the carcinogenic stimulus is not known and speculation whether etiology is endogenous or exogenous is futile. □

## REFERENCES


1. **Huffman, J.W.:** Management of malignant genital tumors in female children. *Clin Obstet Gynecol 14:*1088-1108, 1971.
2. **Novak, E.R., Woodruff, J.D.:** *Gynecologic and Obstetric Pathology,* Seventh edition, W.B. Saunders Company, Philadelphia, 1974.
3. **Volkmann, R.,** cited by **Schuchardt, R.:** Uber die papillaren Scheidemsarkome kleiner kinder. Verb (Zweiter Kongress) Deutsch Ges Gynek p 237, 1885.
4. **Stuart, A.E.:** Long survival after vaginal sarcoma botryoides. *Brit J Urol 48:*452. 1976.
5. **Davos, I., Abell, M.R.:** Sarcoma of the vagina. *Obstet Gynecol 47:*342, 1976.
6. **El-Mahdi, A.M., Marks, R. Jr., Thornton, W.N., et al:** Twenty five year survival of sarcoma botryoides treated by irradiation. *Cancer 33:*653-656, 1974.
7. **Simpson, E.E.:** Immature botryoid tumors of the cervix. *Arch Path 35:*535-545, 1943.
8. **Laufe, L.E., Meyers, L.L.:** Mixed mesodermal tumors of the uterus. *Obstet Gynecol 4:*548, 1954.
9. **Novak, Emil:** Personal communication.
10. **Hertig, Arthur T.:** Personal communication.
11. **Rutledge, F., Sullivan, M.P.:** Sarcoma botryoides. *Ann NY Acad Sc 142:*694, 1967.
12. **McFarland, J.:** Dysontogenetic and mixed tumors of the urogenital region. *Surg Gynecol Obstet 61:*42, 1935.
13. **Exelby, P.R.:** Solid tumors in children: Wilms tumor, neuroblastoma and soft tissue sarcoma. *Cancer J for Clinicians 28:*146, 1978.
14. **Taylor, C.W.:** Mesodermal mixed tumor of the female genital tract. *J Obstet Gynecol Brit Emp 65:*177-188, 1958.
15. **Dunster, M.D., Bennett, D.:** Sarcoma botryoides of the cervix uteri. *J Obstet Gynecol Brit Emp 60:*85-86, 1950.
16. **Hilgers, R.D., Malkasian, G. Jr., Soule, E.H.:** Embryonal rhabdomyosarcoma (botryoid type) of the vagina. A clinicopathologic review. *Am J Obstet Gynecol 107:*484-502, 1970.
17. **Robboy, S.J., Prat, J., Welch, W.:** Vaginal tumors. *Contemporary Obstet Gynecol 11:*124, 1978.
18. **Hertig, A.T., Gore, H.:** Tumors of the female sex organs. Part 2: Tumors of the vulva, vagina and uterus. Armed Forces Inst Path: *Atlas of Tumor Path,* Section IX, E Fascile 33, Washington National Research Council, 1960.



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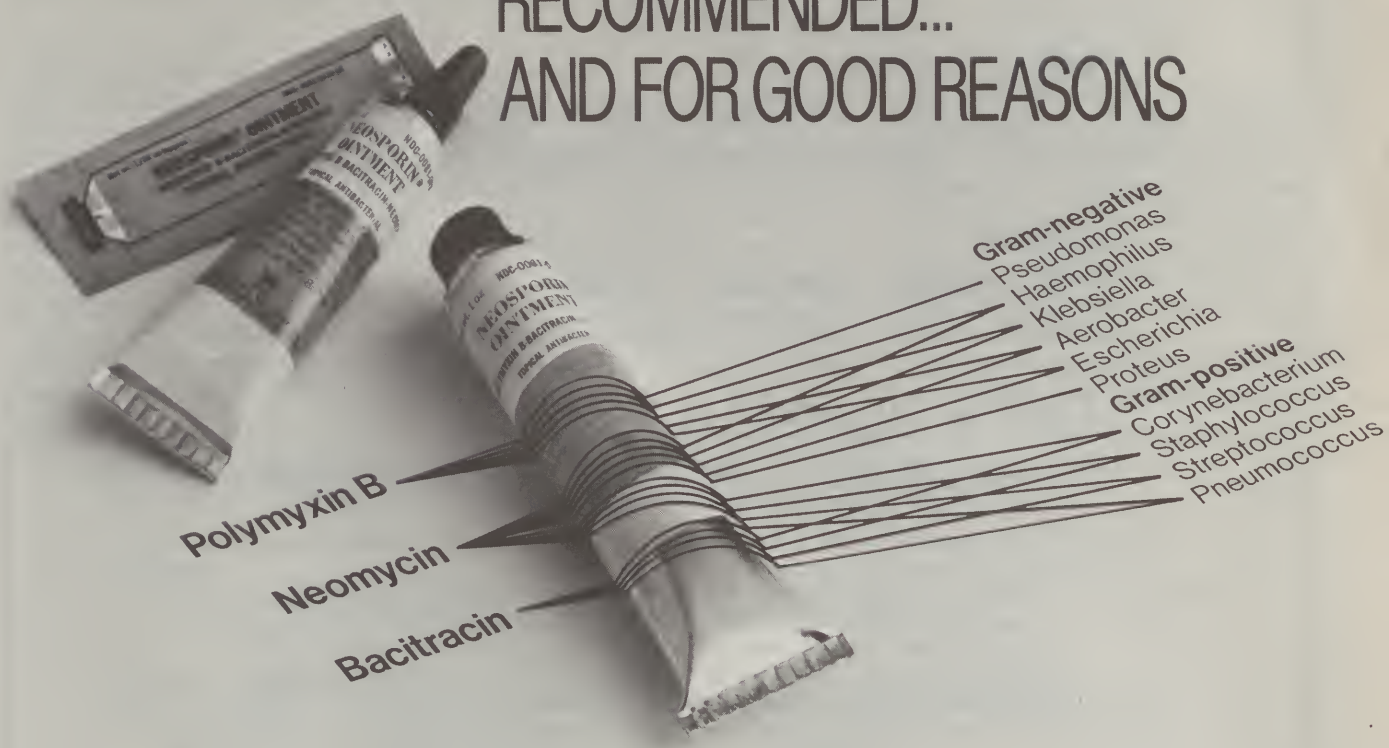


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# How to detect drug abusers—a true story

**Robert G. Little, MD**

Methaqualone (Quaalude, Parest, Sopor) is a hypnotic which has been abused nationwide.[1-8] I recently learned some lessons, by first-hand experience, regarding the modus operandi of the abusers. By formal letter, I have expelled from my practice the three young men who taught me the lessons.

Since it is a crime to prescribe a Schedule II controlled drug to a known abuser (user or pusher), I want everyone to be alert for a potential abuser.

Each of these methaqualone abusers had several identical traits. These traits, when considered together, may distinguish abusers from honest patients with true insomnia.

*Dr. Little is a family practitioner in Dauphin County. He is on the staff at Harrisburg Hospital and Polyclinic Medical Center.*

**Modus operandi**

The abuser is a young man, neatly dressed, who comes with a *trivial complaint* that is vague but impossible to disprove, e.g., cough, itching, or headache. He discourages an expensive work-up, but says that a certain medicine always helps when this problem appears. This trivial complaint is merely his "entree."

Next, he says he has a long standing sleeping problem "since college" or

## Law enforcement officers advise physicians on drug abusers

**Don't leave prescription pads around.**
*Addicts want them for effecting forgeries.*

**Don't write a narcotic prescription in lead pencil.**
*Avoid writing any Rx in pencil; many are changed to call for morphine.*

**Don't write narcotics this way:**
**Morphine HT ½#X** *or*
**Morphine HT ¼#10**
*Several Xs or zeros can be added to raise the amount. Use brackets or spelling.*

**Don't carry a large stock of narcotics in your bag.**
*Addicts are on the lookout for these in doctors' offices and cars.*

**Don't store your office supply where patients can get at it.**
*Avoid storage near sink or urinal. The patients may ask to use these.*

**Don't fall for a good story from a stranger claiming ailment that usually requires morphine.**
*The addict can produce bloody sputum, simulate bad coughs or other symptoms. Make your own diagnosis.*

**Don't give narcotic Rx to another without seeing the patient.**
*Addicts have posed as nurses to get doctors to prescribe narcotics.*

**Don't write for large quantities of narcotics unless unavoidable.**
*Diversion to addicts is a profitable business.*

**Don't prescribe narcotics on the story that another MD had been doing it.**
*Consult that physician or the hospital records whenever possible.*

**Don't leave blank forms signed at the office for nurses to fill in.**
*Signed blanks are bad practice and many have been stolen by addicts.*

**Don't treat an ambulatory case of addiction. Addicts must be under proper control.**
*Addicts go to several MDs at a time.*

**Don't dispense any narcotics without keeping a record of it.**
*Bedside and office administration are permitted without record.*

**Don't buy your office narcotic needs on Rx blanks.**
*The law requires you to use an official order form.*

**Don't resent a pharmacist's call for information about a Rx you may have written.**
*The pharmacist is held responsible for filling forgeries. Please cooperate.*

"due to his job pressures." *The only medicine that helps* him is Quaalude (or Parest). When offered any other sleeping medication, he says he has tried it and it is ineffective. He listens politely to counseling regarding the addictive potential of sleeping pills, but assures the doctor that he is not dependent on pills; he simply cannot sleep without Quaalude. If a small supply of this medication is offered, he asks for 50 or 100 so that he won't have to return so soon. If you insist on giving a smaller supply, he accepts and appears grateful.

He returns in a couple of weeks with another trivial complaint, but states later that he is going out of town for an extended period, e.g., to Europe, to Florida to visit relatives, or to try a new job. He will need *a new supply* of Quaalude because his supply will be gone and he does not know any physicians where he is going.

He often lists a *phony address* or phone number which you will discover when his bill is mailed. He rarely pays cash; he usually asks to be billed or writes a check which may be returned due to insufficient funds. If you insist on cash as a basis for any more pills, he will comply, because he can sell each tablet on the street for $10.00. He will preserve each source of pills as long as possible. One area physician confided that one abuser left with an unpaid bill of $83.00.

Eventually the abusers are seen together or come for appointments on the same afternoon. The *similarity of their case histories* becomes striking.

One of my patients lied about the number of pills the pharmacist had dispensed. This prompted a call to the pharmacist who agreed to review his records of recent Schedule II drug dispensing. Surprisingly, all three names were there! All had brought prescriptions from multiple physicians located over a wide area. Calls to other pharmacies revealed the same facts.

Then I called the local Drug Enforcement Agency. This agency was aware of two of the patients' names, but they could not prosecute because each prescription was written and dispensed legitimately.

### Suggestions

Based on these experiences, I recommend that physicians

- don't prescribe Quaalude if a patient requests it or any Schedule II drug by name;
- insist on writing for *small* quantities of dangerous drugs and be suspicious of anyone who requests larger supplies;
- ask several local pharmacies to review their Schedule II records when you suspect an abuser;
- notify your regional Drug Enforcement Agency.

### REFERENCES


1. **Rock, N.L.:** Methaqualone abuse among U.S. Army troops stationed in Europe. *Int J Addict 13:*327-35, 1978.
2. **Falco, M.:** Methaqualone abuse: foreign experience and U.S. drug control policy. *Int J Addict 11:*597-610, 1976.
3. **Kochansky, G.E.:** Methaqualone abusers: a preliminary survey of college student. *Dis Nerv Sys 36:*348-51, 1975.
4. **Schwirian, P.M.:** Personalities and attitudes of non medical users of methaqualone. *Arch Gen Psych 30:*525-30, 1974.
5. **Russell, J.F.:** Methaqualones - "Heroin for lovers." *J Miss State Med Assoc 14:*496-8, 1973.
6. **Pascarelli, E.F.:** Methaqualone abuse, the quiet epidemic. *JAMA 224:*1512-4, 1973.
7. **Inaba, D.S.:** Methaqualone abuse: "Luding out." *JAMA 224:*1505-9, 1973.
8. **Budge, T.P.:** Quaalude alley: a one way street. *Amer J Psych 130:*217-9, 1973.



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# psychiatry in general practice

## Drug therapy: from compliance to cooperation

**Kenneth J. Weiss, MD**
**Thomas Wolman, MD**

Many patients we treat for hypertension, anemia, schizophrenia, anxiety, and other chronic conditions, are not taking their medications as prescribed. Such compliance problems, failures to maintain or complete a drug course, can exceed 50 percent.

The sad irony is that despite an extensive workup, the culmination of our efforts, the prescription, may be the weak link in the therapeutic chain. How we educate our patients, and the lines of communication between doctor and patient influence this therapeutic chain. By examining the prescribing process as an interpersonal event, we shall try to illuminate barriers to cooperation as they arise out of misconceptions and faulty communication.

### Prescribing process

The notion that prescribing a drug is followed automatically by the patient's taking it and being cured has been called a "comfortable delusion."[1] We are tempted to want to see the prescribing process as a *linear* one, a one way street, where the patient is a silent partner. From such an authoritarian standpoint, failure to take the medication as prescribed is seen as non-compliance. This imples that the patient should bend to the doctor's will because the doctor knows best.

How we convey our wisdom and how much the patient participates often determine the results of drug therapy. Gutheil has used the term "participant prescribing" as a paradigm of the prescribing process.[1,2] The drug therapy is considered in the context of the patient's lifestyle and experience, providing education about diagnosis and treatment, and a medium for feedback to the doctor about the therapy.

Rigidity breeds rigidity. A physician is forced to comply with the role of prescriber, just as a patient is forced to swallow what is prescribed. If you doubt this, notice how difficult it is to complete an office visit without handing the patient a prescription. The role requirements of patient and physician are so stringent at times, that to deviate would create tension for both. Prescribing, a tension-reducing ritual, nonetheless may be tangential to the patient's needs. Yet, in the end, the patient gratefully accepts the prescription but may not get it filled.

Apart from the prescription writing, the prescribing process has three essential elements: 1) discussing the nature and prognosis of the illness; 2) discussing what good and bad effects should be expected; 3) fitting the regimen into the patient's lifestyle.[3] The patient should have an opportunity to react and contribute to the treatment plan.

Our thesis is that prescribing must be expanded to include the experience of the patient in the treatment process. Lines of communication must be opened so that misconceptions do not undermine the treatment.

### Barriers to cooperation

A number of factors increase the risk of a drug therapy not being completed. Any chronic treatment (maintenance or prophylactic, e.g., antipsychotic, antihypertensive) tends to diminish in its importance to the patient over time: "The longer a patient has remained well, the more he may be prepared to gamble on continued good health."[4]

Since stopping these treatments produces no immediate effect, the risk is not apparent, and the decision to stop may not be communicated to the physician. Taking medication symbolizes illness to many patients who would rather dispense with this stigma altogether.

As Blackwell points out,[5] patients who stop their drugs are a curious group, since they don't necessarily stay away from the doctor. Although no one has been able to foretell who will complete treatment, attending to difficulties in your relationship with the patient provides clues.

Personality traits such as suspiciousness, hostility (or its equivalent, automatic obedience), and hypochondriasis often predispose toward lack of cooperation. You may notice that communication is difficult, that the patient is not listening but rather trying to prove some pre-formed ideas about the inadequacy of medical care. On the physician's side, the biggest barrier to successful drug therapy is failure to provide the patient with a rationale and reasonable expectations, and failure to educate about therapeutic and side effects.

In a large study of a pediatric population,[6] a physician's lack of empathy, or unfriendliness, caused poor cooperation in parents. Least satisfied were the parents who were disappointed in their expectation to learn about the illness. Conditions perceived as serious were associated with high compliance, whereas complex instructions

*Dr. Weiss is clinical assistant professor of psychiatry at Jefferson Medical College and staff psychiatrist at the Coatesville Jefferson program VA Outpatient Center, Philadelphia. Dr. Wolman is clinical assistant professor in psychiatry at the college, attending psychiatrist at Thomas Jefferson University Hospital, and staff psychiatrist at the VA clinic, Coatesville-Jefferson branch.* *This is the eighth article prepared under Dr. Wolman's supervision for inclusion in the series on office counseling for primary care physicians. The series is a project of the departments of psychiatry of the state's seven medical schools in cooperation with the Pennsylvania Psychiatric Society.*

were not followed readily.

Studies have shown repeatedly that most children fail to complete a course of penicillin for streptococcal pharyngitis.[7,8] Some authors suggest that this is because physicians prescribe penicillin too liberally and for too long.[8] A child who feels better after one or two days is unlikely to accept pills for another week.

Elderly patients present different problems. Memory and attention deficits and self-neglect form barriers to effective prescribing. Third parties frequently need to be recruited to help prevent errors of commission and omission.

Most authors agree that familiarity, consistency, and continuity of care strongly favor cooperation in drug therapy. Complicated polypharmacy regimens have less likelihood of succeeding under even the best conditions. Mazzullo exhorts us to pay attention to the physical characteristics of the pills, since confusion among look-alike drugs causes many errors.[9]

Familiarity with the patient's lifestyle should guide our prescribing habits. "How can a doctor give a prescription for a drug to be taken three times a day with meals if the doctor has no idea if the patient indeed eats three meals?"[3] Many medications can be prescribed once or twice a day because of their long half lives, e.g. antipsychotics, antidepressants, and anticonvulsants, thus further minimizing inconvenience and errors of omission.

Mindful of these general factors that affect the success of prescribing, let us turn to specific interpersonal difficulties and misconceptions that form barriers to physician-patient cooperation.

### Clearing the air

Illness necessarily involves anxiety, and with anxiety, distorted thinking and judgment. Specifically, wishing to eliminate the feeling of being sick causes a number of misconceptions between physician and patient (from both sides). These faulty formulations interfere with the prescribing process. Listed below are examples of misconceptions that patients have about their drug therapy.

- Taking medication = being sick, therefore not taking it = being well.
- I feel better, therefore I don't need the medication.
- I can regulate my own medication according to how I feel.
- My physician will be displeased if I complain about the side effects.
- If one pill is good for me, two are better.
- I'm being used as a guinea pig.
- No one can tell me what is best for me.

These illustrations fall mainly along the axes of autonomy versus compliance and acceptance versus denial. The operative principle is that people like to exercise free choice and would rather not see themselves as ill. (Obviously we see the opposite too, patients who crave domination and cling tenaciously to their patienthood.)

Your drug therapy may have shameful and stigmatizing implications and may deprive your patient of the feeling of self control. Although you may suppose that it would be reassuring to be on the road to health, the medication may be no more than an annoying reminder of sickness, advancing age, and mortality.

The physician's task is to contribute to an alliance built upon rationality, acceptance, and flexibility. The patient's anxieties need to be acknowledged specifically. You may need to point out, for example, that although taking pills is an irritating prospect, choosing to do so likely may prevent future grief.

Authoritarianism and angry confrontation have little place in the prescribing process since they confirm the patient's suspicions that you lack understanding. Your empathy acknowledges that no matter how strange the reason, the patient's behavior seems sensible to himself. This attitude on your part should encourage further reality orientation.

Despite your attempts at education, feeling better is a powerful motivator to stop medical treatment. In many treatments, such as that for schizophrenia, the medication has produced a remission, but frequently the patient chooses to seek refuge in the inner world. This particular treatment is complicated by the schizophrenic's fear of being controlled and need for safety.

Feeling better also motivates children to refuse medications after the sore throat is better. Their logic can be corrected when they and their parents are told about the possible sequelae (cardiac and renal). This also may recruit a few more days of cooperation.

Maintenance and prophylactic therapies tend to appear irrational to patients. Frequently heard is "I know when my pressure is up." This is dangerous. A patient who chooses self-regulation moves toward autonomy but may deny the basic defect. One approach to treating such a patient is to prescribe a home sphygmomanometer.

When patients admit they have abandoned treatment, ask a nonjudgmental question like: "What do you recall about why we originally started this treatment?" With this, you call upon the patient's capacity for self-observation, and you reinstate your working alliance.

Patients who fail to tell you that

they have stopped treatment often have experienced unexpected side effects. When confronted by you, they may respond that they didn't want to bother you or hurt you. Our experience is that the patient fears retaliation from the powerful authority figure. Prevention is the key in this situation. Prepare your patient for side effects especially when a high rate of side effects is prevalent, e.g. with psychotropic drugs. These drugs frequently affect the autonomic and motor systems and constitute a major source of misunderstandings and treatment failures.[10]

Other miscommunications arise when the patient feels that the medication is to be taken as a PRN. A classic example given by Mazzullo and Lasagna is the patient who interprets the directions for a diuretic, "for fluid retention," to mean that the pill is used to help retain water.[3] Other patients figure that they will do the physician one better and get well twice as fast by taking excess medication.

Other patients crave medication and interpret it as a gift from the physician, or as a relationship substitute. Such patients are difficult and frustrating. They become angry and disappointed because the medication never satisfies the hunger. Havens suggests that we opt out of the authoritarian model, and along with giving the medication, we eventually discuss the emotional basis of the craving, i.e., the need for affection. Frank addiction, supported by a warped therapeutic alliance, occurs as an extension of this paradigm, and deserves a separate discussion.

Examples of misconceptions or faulty assumptions by the physician are listed below.

- The patient is neither capable of nor interested in understanding the illness.
- I have communicated clearly the rationale for my prescription.
- The patient would tell me if there were a problem in taking the medication.
- The patient trusts me and knows I have his best interests in mind.
- Medications don't cost much.

These paradigms indicate that many of the physician's barriers to drug therapy lie in the realm of misunderstanding the patient's experience and attitudes. When a physician is defensive to the extent that informing the patient about medical procedures is giving up too much, the patient will register this attitude at some level and respond with a less than satisfying result. Havens cautions: "The authoritative doctor may not listen or may frighten the patient out of talking, so that the patient conceals side effects, possible improvements in the dosage and scheduling, or the fact that he is not taking the medicine at all."[11]

Although we cannot recommend giving your patients brief courses in pathophysiology, we do suggest that you engage the patient's interest and intelligence in a discussion of the disease process. Many patients take pride in themselves when their physician thinks enough of them to speak frankly. A sense of mastery comes with such participation. This model has multiple dividends, including better cooperation and mutual trust, improving patient and physician morale, and possibly reducing the incidence of lawsuits.

We urge you to complete the communication circuit by asking the patient to repeat what is understood about the disease process and the specifics of the treatment regimen. The patient should be encouraged to voice concerns during the treatment, especially where side effects are expected. This is helpful particularly in dealing with distrustful or paranoid patients. Showing the patient that you appreciate the cost of medications is advisable, for example, by prescribing generics or encouraging shopping for a reasonable pharmacy.

## Toward cooperation

Although it is difficult to give advice about improving the "chemistry" of physician-patient relations, we hope that clarifying misunderstandings will improve the climate in which medical treatment is given.

In drug prescribing, as in all transactions, we necessarily participate in the patient's life experience, and the patient in ours. It is in acknowledging the symbolic value of medication and the relationship aspects of drug therapy that we come closer to an empathic, cooperative position.

Although medical treatments possess an "illusion of certainty,"[1] the physician and patient must be aware that uncertainties can be discussed. In moving from a model of compliance to one of cooperation, each party accepts a portion of the responsibility for success in drug therapy.

We offer the following suggestions for enhancing cooperation in drug therapy.

- Promote a feeling of partnership with your patients. Each of you has an indispensible role in the drug therapy.
- Make treatment planning a joint effort, combining the best of your expertise with the patient's needs, constraints, and motivations. If a particular treatment is difficult, let the patient know you are familiar with it. Feeling understood solidifies the patient's commitment.
- Minimize the risk of medication errors by giving specific instructions, and as few medications as few times a day as possible. Anticipate difficulties in cooperation, and work with the patient toward a solution.
- Educate. Misinformation coupled with anxiety leads to misconceptions and fears. Deal with this barrier to cooperation preventively. The patient should be aware of what to expect (therapeutic and side effects) and what not to expect from the medication.
- Acknowledge the patient's negative reactions to you or the treatment, since these feelings often reflect life issues which the patient cannot verbalize directly.

## REFERENCES


1. **Gutheil, T.G.:** Psychodynamics in drug prescribing. *Drug Ther* 7:35-40, 1977.
2. **Gutheil, T.G.:** Drug therapy: alliance and compliance. *Psychosomatics 19:*219, 223-225, 1978.
3. **Mazzullo, J.M., Lasagna, L.:** Take thou . . . but is your patient really taking what you prescribed? *Drug Ther 2:*11-15, 1972.
4. **Blackwell, B.:** The drug defaulter. *Pharmacol Therapeutics 13:*841-848, 1972.
5. **Blackwell, B.:** Patient compliance. *N Engl J Med 289:*249-252, 1973.
6. **Francis, V., Korsch, B.M., Morris, M.J.:** Gaps in doctor-patient communication. *N Engl J Med 280:*535-540, 1969.
7. **Mohler, D.N., Wallin, D.G., Dreyfus, E.G.:** Studies in the home treatment of streptococcal diseases. I. Failure of patients to take penicillin by mouth as prescribed. *N Engl J Med 252:*1116-1118, 1955.
8. **Charney, E., Bynum, R., Eldredge, D., et al:** How well do patients take oral penicillin? A collaborative study in private practice. *Pediatrics 40:*188-195, 1967,
9. **Mazzullo, J.:** The nonpharmacologic basis of therapeutics. *Clin Pharmacol Ther 13:*157-158, 1972.
10. **Van Putten, T.:** Why do schizophrenics refuse to take their drugs? *Arch Gen Psychiatry 31:*67-72, 1974.
11. **Havens, L.L.:** Some difficulties in giving schizophrenic and borderline patients medication. *Psychiatry 31:*44-50, 1968.

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# practice management

## When pegboard gives way to computer, questions loom

**Leif C. Beck, LL.B., CPBC**
**Vasilios J. Kalogredis, JD, CPBC**
**Geoffrey T. Anders, CPA, JD**

As volume demands grow and automation becomes worthwhile for the medical office, physicians are faced with a number of difficult choices. When the practice's pegboard can no longer keep up with the demands placed on it, a major question will be whether the practice should turn to an in house computer or an outside service bureau. Each approach has its advantages, but each also has its costs and traps for the unwary.

Admittedly, our fundamental bias favors the computer purchase. The degree of flexibility obtained cannot be equalled by an outside service bureau. Rather than adapting a system to fit the practice, the office contracting with an outside service must fit into that bureau's routines. Still, service bureaus do fill some practices' needs and should not be overlooked as an alternative.

For many reasons an office may not get its investment back from an in house computer. Physicians with few years of active practice remaining until retirement should be particularly shy of major equipment purchases. Other physicians or groups just may want to keep themselves and their staffs out of the world of CPUs and floppy disks. The extra cost of the service bureau then could be dollars well spent.

Service bureaus sometimes are considered an interim measure before the big step of going in house. Engaging the right service bureau may be the best way to train the staff and physicians in the rigors of computerized processing. This interim step may help avoid the turnover of office managers which seems to accompany in house computerization.

At this time, the interim step could be the correct business step. Minicomputer hardware prices are beginning to trend downward, perhaps following the path of the electronic calculator. Software design certainly will improve with time as more systems are field tested. Thus, as prices drop and capabilities improve, we await a further shake out among mini-computer manufacturers and sellers.

For those who decide to employ an outside computer service bureau, careful selection and negotiation are essential. Ideally, the selection process is a mixture of steps paralleling a good employee hiring routine and the "Request for Proposal" process in purchasing an in house system.[1]

### Initial screening

The first step in the selection process is easy: create the largest pool of applicants possible. No referral source for possibilities should be overlooked—the yellow pages, other physicians, hospitals, practice consultants, and other advisors.

The initial screening can be handled effectively by telephone, preferably anonymously, and need not involve the physicians. An office manager or senior assistant can do it.

Services which do not provide direct display mechanism (usually a CRT) placed in the physician's office can be eliminated. We consider it essential to have basic patient information and *current* patient account balances available for reference.

Mail order type services cannot meet this preliminary requirement. Services that supply print-outs weekly or monthly as the only source of reference leave a practice unable to deal with patient payment problems or inquiries.

The second screening test is straightforward, too. Be sure that companies engage *only* in medical billing activities and avoid firms with different subsidiaries servicing different types of businesses. Service bureaus with broadly ranging clientele are less likely to tailor themselves to medical practice needs. Even in the unlikely event that such a bureau can handle a practice's demands from the outset, system updates will be slow.

The initial contact also must focus on the available applications and specific practice needs. Multiple office locations and other situations seem difficult to accommodate from a service bureau's standpoint.

Hospital based practices may benefit from a bureau's ability to tie into the hospital's computer system for data-sharing, although few services with this capability will be found. These and other variations in medical practices may prevent a practice from going with a service bureau at all or limit the possibilities to a single company.

Assuming there is no compelling reason to consider only one possibility, the screening questions should emphasize the services desired. Physicians often consider only patient and third party billing, but many practices would be advised to look for more comprehensive services such as patient recall, appointment scheduling, clinical (diagnosis/treatment) cross reference, and general bookkeeping. Some service bureau's systems offer word processing by placing a typewriter/printer in the physician's office.

Although a practice rarely should attempt to connect all of its systems at once, the initial screening and later negotiation process should encompass both the timetable and costs for each routine which may be automated.

Trade-offs and compromises will dominate the selection considerations at this point. To rank the companies contacted, the practice must have established the minimal and optimal range of services it desires.

The last initial test should be a re-

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*The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.*

quest for the computer bureau's two most recent years' financial statements. These should be sent directly to the practice's accountant or other advisors for evaluation of the company's economic stability.

**Finding the best fit**

The initial screening process narrows the field. Surviving candidates should be contacted in writing for a proposal and detailed description of the service's routines. This part of the process mirrors the "Request for Proposal" process used in purchasing computers, as we described in a previous article, and has the same merits.

Requiring the service bureaus' replies in a format organized by the practice saves time. Comparing services based upon sketchy advertising brochures is ineffective. No matter how thoroughly the practice examines the candidates' preprinted circulars and patterned sales presentations, questions will remain unanswered. Furthermore, the practice should include the bureau's responses to its specifications in the final contract. The only way to accomplish that goal is to get it in writing.

The practice's request for information should note that several other bureaus (specified by name) are being asked to supply proposals. After that introduction, present a description of the practice, its patient and transaction volumes, and the services desired.

Primarily the request should establish a format for exploring each phase of each service from input to output, as well as the overall experience characteristics of the bureau's operations.

Beginning with input, the request should explore whether current practice routines will supply the necessary information. To help determine what changes are needed, enclose copies of the practice's current forms—fee slips, hospital notebook, etc.

Will additional forms be needed? Who will convert the manual records onto the computer? How and when will this be accomplished? What system of input control is recommended? Will the bureau provide on-going assistance in this area as the practice changes?

A service bureau commonly fails to provide leadership after its system is installed. Guard against this and be certain of the extent of staff training provided by the bureau.

After that, the request must seek information as to the service's processing routines and capabilities. We suggest the following questions. How often does the central computer contact the practice's terminal? How soon after data entry will insurance forms be prepared?

What is the access time to retrieve specific information or patient account? What timetables are available for patient billings, and delinquent account notices? Can the bureau prorate charges to bill more than one party *i.e.* medicare and the patient simultaneously? Will insurance forms be printed even when all the required information is not on file?

Each aspect of the processing must be questioned carefully so that a comprehensive comparison of systems can be made. The practice must accept whatever system the selected bureau offers. Later attempts to change the service bureau's processes invite trouble, so initial evaluation and choice is crucial.

Copies of each document produced by the service bureau must be requested. Patient bills, and clerical and management reports should be concise and well planned. The output should include reports monitoring unpaid insurance claims, annual summaries for patients' tax purposes and major medical claims, and summaries of disallowances by each insurance company. Determine whether billing output is sent directly to patients and third parties or returned to the practice and what system of output control is recommended.

Besides the specific bureau routines, a variety of overall considerations, costs, and contract provisions should be explored. How often is the system down? Who bears the costs (service, insurance, and repair) related to the office terminal or other in house equipment? Are there extra telecommunications charges? Will additional telephone equipment or site preparation be necessary? Will the bureau guarantee to update its processes?

Will the bureau indemnify the practice from loss due to the service's errors and omissions or due to breach of patient confidentiality? Beware of service bureaus which are not insured against both types of liability and which do not subscribe to and follow the AMA's guidelines for patient confidentiality. Once a decision is reached, the practice is responsible for obtaining patient authorization to release billing and other information to the service bureau.

The service bureau should guarantee its quoted price for a stated time. This protection is essential. Should the contract be terminated, in what form will the practice's records be returned? Require a copy of the standard contract as part of the requested information.

The questions and concerns are myriad and require careful thought in preparing the request for information. The process is time consuming but cost effective in the long run.

**Making the choice**

Once the physician or group receives the responding proposals, the evaluation process can begin. There are two system questions. How well do the available services fit with the optimal combination of desired services, and how well thought out is the system

under consideration?

To answer the first question, rank the practice's desires. This method provides a scale for rating the service bureaus' responses.

The second inquiry is not answered so easily. The physician, office manager, and staff responsible for each routine should evaluate how well the service bureau system operates in each area of responsibility.

Are patient records conveniently and easily accessible? Are reports designed effectively? For example, do delinquent account reports age the outstanding balance, show the last payment date, the last collection action taken, and the patient's phone number?

Each proposed report form must be examined carefully. The practice probably will work with that form as long as the bureau is engaged. Involving each member of the staff in the inquiry will not only yield a better evaluation, it will help insure the employees' acceptance of the system selected.

Further inquiries are more straightforward. How do the costs compare? Are any of the services willing to guarantee cost savings over the office's present system? Some services do estimate and guarantee savings. If so, be certain the method of measuring savings is spelled out and takes into account the usual growth of the practice before estimating benefits.

Before making a final choice, consider how accommodating the service bureau was in the inquiry process. If it was not helpful, think twice before you are hooked onto its system.

### Final actions

The two final stages of selection are reference checking and contract negotiation. Reference checking can be approached in one of two (or both) ways. Obtaining a list of *all* the company's medical practice customers in the area is one method. The second is to obtain a list of all practices which have dropped the service in the last two years.

In each approach, every listed practice should be contacted. Be certain to visit several practices still on the service bureau to discuss the service company's procedures, responsiveness, down time, and other problems. The reference checking should be done on two levels—physician to physician and operator to operator.

A competent attorney experienced with computer contracting must review the proposed final agreement to provide any hope of avoiding pitfalls. Standard service bureau agreements are written with only the service bureau's interests in mind.

As a major item in the contract, include the service bureau's response to the original request for information. Since it should have included everything that was promised, it is the practice's best protection. The usual items, such as limitations of liability, nonassignment of the contract, and provisions as to contract breach in the proposed agreement also must be reviewed.

### Conclusion

Although the selection process is time consuming it is well worth the effort. Without the suggested careful pre-planning and deliberation, a practice can anticipate difficulties. Even with careful selection, the level of success in changing to a service bureau will depend on the employees' following the service bureau's regimen and procedures. □

[1]Selecting a computer for your practice is an exacting process," PENNSYLVANIA MEDICINE, August, 1979.


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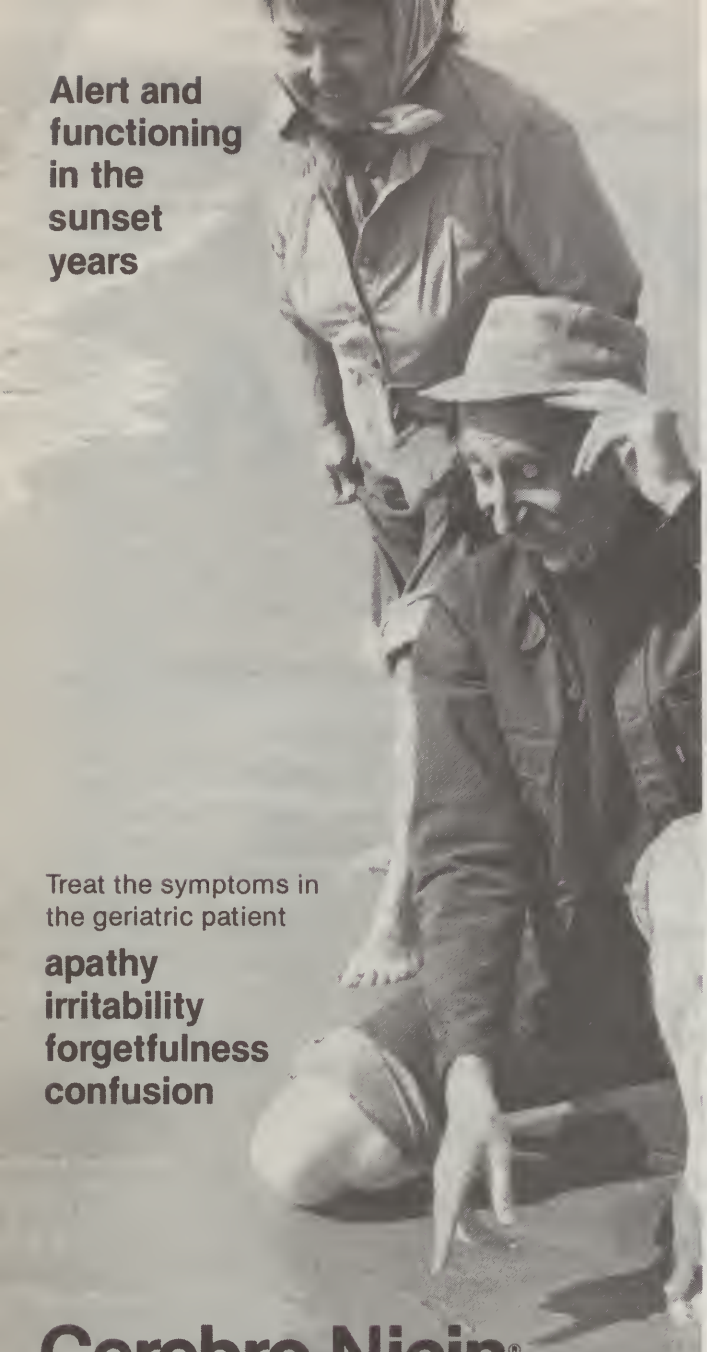

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William A. Carter, MD, Family Practice, Norlanco Rd., RD 3, Elizabethtown 17022
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Barton L. Halpern, MD, Ophthalmology, 1617 Santa Barbara Dr., Lancaster 17601
Frederick J. Heinle, Jr., MD, General Surgery, 1235 Wheatland Ave., Lancaster 17603
Terrence H. Jones, MD, Family Practice, 130 S. Penn St., Manheim 17545
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PHILADELPHIA COUNTY:
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Lee A. Barber, MD, Internal Medicine, 20 Lodges Ln., Bala Cynwyd 19004
Susan C. Benes, MD, Ophthalmology, 3407 Warden Dr., Philadelphia 19129
Perry Black, MD, Neurological Surgery, Hahnemann Hosp., Dept. of Neuro. Surg., Philadelphia 19102
Richard D. Burns, MD, Radiology, 131 Lantern Ln., Gulph Mills 19406
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Soo K. Chung, MD, Anesthesiology, 192B Willowturn, Mt. Laurel, NJ 08054
Kokila D. Doshi, MD, Anesthesiology, 1000 Walnut St., Apt. #1006, Philadelphia 19107
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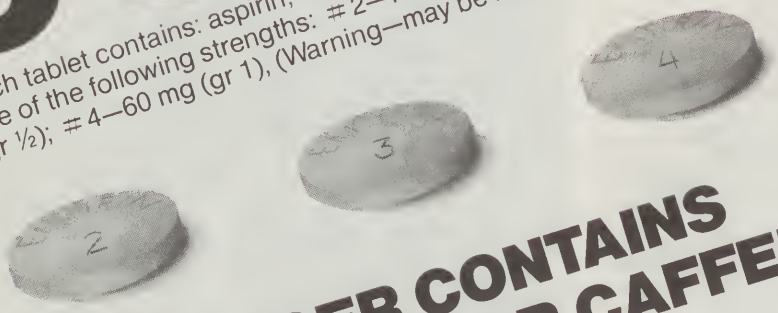


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# physicians in the news

Five thousand fellow members of the American Dermatology Foundation recently selected **Hugh M. Crumay, MD,** "Practitioner of the Year." Dr. Crumay, co-founder of the Pennsylvania Academy of Dermatology, is a consultant at the Hershey Medical Center.

The American Institute of Ultrasound in Medicine honored **Marvin C. Ziskin, MD,** with its Presidential Recognition Award. Dr. Ziskin is professor of radiology at Temple University School of Medicine and adjunct professor of biomedical engineering at Drexel University.

**Robert Austrian, MD,** received the Torch of Learning Award of the Philadelphia Medical Division of the American Friends of Hebrew University. Dr. Austrian is professor and chairman of the research medicine department of the University of Pennsylvania School of Medicine.

Northampton County Medical Society recently installed **Theodore P. Burger, MD,** as president. Dr. Burger is on the staff of St. Luke's Hospital, Bethlehem. Other officers elected are **Drs. Kenneth H. Wildrick,** president elect; **Charles D. Saunders,** vice president; **John H. Hobart,** secretary; and **Walter K. Peters,** treasurer.

**Barry Green, MD,** has been appointed to the board of directors of the American Cancer Society, Philadelphia Division. Dr. Green is president of the North Penn Unit of ACS and a staff member of North Penn Hospital.

**Joseph B. Conahan, Jr., MD,** has been elected to the board of directors of Pocono Hospital. Dr. Conahan serves on the boards of the Health Planning Advisory Committee of Monroe County and the Monroe Chapter, American Cancer Society.

**Doris G. Bartuska, MD,** has been elected to the board of advisors of the Medical College of Pennsylvania. Dr. Bartuska is professor of medicine and associate professor of clinical pathology at MCP and director of its endocrinology and metabolism section.

**Quazi Jamil, MD,** has been named county chairman for the 1980 Heart Fund Campaign for the American Heart Association, Allegheny Mountain Pennsylvania Chapter. Dr. Jamil is chairman of the intensive care/coronary care committee at Bradford Hospital.

**William McNeal, DO,** was chosen doctor of the year by the staff of Clarion Osteopathic Community Hospital. Dr. McNeal is one of the founders of the hospital which he has served for 29 years.

Washington County Medical Society recently elected new officers. **Jon S. Adler, MD,** is president for 1980-81; **E.L. Abernathy, MD,** president elect; **M.E. Ruben, MD,** vice president; and **Erin A. McKinley, MD,** secretary-treasurer.

The Regional Council of Child Psychiatry has installed **Sidney I. Altman, MD,** as president. Dr. Altman is director of Children's Services of the Central Montgomery Mental Health-Mental Retardation Center, Norristown.

The Eastern Pennsylvania Chapter of the American College of Surgeons elected **Joseph J. Prorok, MD,** president. Dr. Prorok is general surgeon on the medical staffs at Allentown and Sacred Heart hospitals.

Philadelphia City Council recently honored **C. Everett Koop, MD,** for his surgical skills and his dedication to pediatrics. Dr. Koop is surgeon in chief of the Children's Hospital of Philadelphia.

**Stephen R. Keister, MD,** has been appointed to the governing board of the Western Pennsylvania Chapter of the Arthritis Foundation. Dr. Keister is an internal medicine specialist on the staff of Hamot Medical Center, Erie.

Bell Telephone Company of Pennsylvania has appointed **Peter J. Devine, Jr., MD,** medical director. Dr. Devine, who has served as associate medical director since 1965, is on the staff of Nazareth and Holy Redeemer hospitals.

**William M. Anderson, MD,** has been elected president of the Central Pennsylvania Foundation of the Cystic Fibrosis Foundation. Dr. Anderson is director of respiratory services and chief of the pulmonary section at Harrisburg Hospital.

**Margaret Gray Wood, MD,** has been elected to the board of corporators of the Medical College of Pennsylvania. Dr. Wood is professor of dermatology and chief of dermatopathology at the University of Pennsylvania School of Medicine.

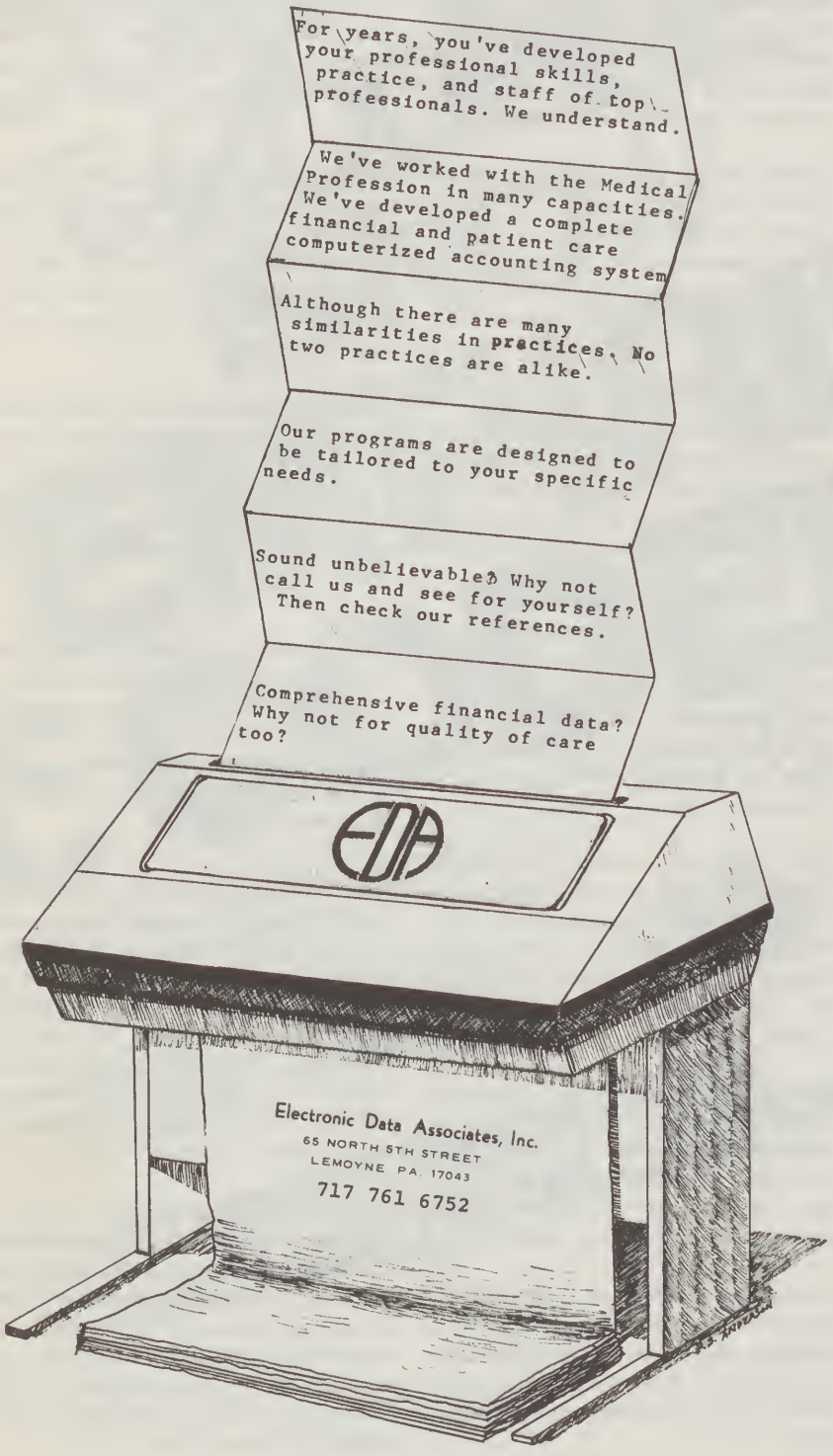
The Veterans Administration recently filled two positions in its medicine and surgery department. **William J. Jacoby, MD,** a 1950 graduate of Jefferson Medical College, is deputy chief medical director. **William R. Merchant, MD,** formerly on the faculty at the University of Pittsburgh School of Medicine, is associate deputy chief medical director.

**Joan Mary Roberts, MD,** chairman of the utilization review committee at Chestnut Hill Hospital, Philadelphia, has been named president elect of the American College of Utilization Review Physicians. Dr. Roberts can be reached at the hospital or at 717 Bethlehem Pike, Erdenheim, Philadelphia, Pennsylvania 19118.

Fourteen physicians from Pennsylvania received fellowship status in the American College of Chest Physicians at its 45th Annual Scientific Assembly in November.

The new fellows accepted the challenge to become one man stop-smoking programs. This addendum to the fellowship pledge is part of the ACCP's new educational program to involve chest physicians in presenting the hazards of smoking to their patients.

The fellows inducted at the meeting are **Drs. Bicher Barmada,** Pittsburgh; **Joseph R. Carver,** Bala Cynwyd; **Mohammad A. Chaudhry,** Wilkes-Barre; **Edward D. Crandall,** Philadelphia; **Charles E. DeFelice,** Chambersburg; **John M. Field,** Hazleton; **William B. Iams,** Harrisburg; **David B. Lerberg,** Pittsburgh; **Ronald V. Pelligrini,** Pittsburgh; **William C. Reeves,** Hershey; **Sirvas R. Samadani,** Pittsburgh; **C. Vaughn Strimlan,** Pittsburgh; **Jalit Tuchinda,** Pittsburgh; and **Hassan C. Vakil,** Media.




**James P. Beittel, MD,** received the 1979 Service to Mankind award from the Lancaster Sertoma Club. Dr. Beittel is a pediatrician active in working with retarded children.

For her fifty years in medical practice, **Eleanor Larson, MD,** received a plaque and pin from the PMS and Tioga County Medical Society. Dr. Larson began practicing in Elkland in 1931.

**George E. Moerkirk, MD,** has been elected president of the Pennsylvania Emergency Health Services Council, an advisory council to the state health department. Dr. Moerkirk is medical director of Sacred Heart Hospital, Allentown.

The Pennsylvania Neurosurgical Society has named **David A. Tilly, MD,** president elect for 1980-81. Dr. Tilly is a neurosurgeon on the medical staffs of Allentown and Sacred Heart hospitals.

Berks County Medical Society honored two members for 50 years of practice: **John A. Focht, MD,** Berks County coroner, and **Fred B. Nugent, MD,** obstetrician and gynecologist.

The American College of Cardiology inducted five Pennsylvanian cardiologists at its 29th Annual Scientific Session in Houston, March 9-13, 1980.

**Robert Zelis, MD,** ACC governor for Eastern Pennsylvania, announced that the following cardiovascular specialists have achieved fellowship status: **Drs. David T. Lowenthal,** Philadelphia; **Abraham Hoordergraaf,** Philadelphia; **Grant Van S. Parr,** Hershey; and **Margo M. Schleman,** Philadelphia.

**Frederick R. Franke, MD,** ACC governor for Western Pennsylvania, announced that **Mohan L. Chabra, MBBS,** Pittsburgh, has achieved fellowship status.

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**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

*Incidence greater than 1%*

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

*Incidence less than 1 in 100*

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

*Causal relationship unknown*

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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# obituaries

*• Indicates membership in the Pennsylvania Society at time of death*

• **Morton Prince Brigham,** Haverford; Temple University of Medicine, 1950; age 56, died January 3, 1980. Dr. Brigham was associate dean of Temple's medical school.

• **James Wilton Daly,** Bryn Mawr; Jefferson Medical College, 1948; age 55, died January 1, 1980. Dr. Daly was a staff member at Lankenau Hospital and was on the faculty at Thomas Jefferson University.

• **Amil Martin Duster,** Butler; Jefferson Medical College, 1924; age 80, died December 29, 1979. Dr. Duster practiced in his hometown for 55 years.

• **Louis C. Fulton,** Pittsburgh; University of Louisville School of Medicine, 1911; age 96, died January 17, 1980.

• **Alan Leonard Glaser,** Pittsburgh; Vanderbilt University, 1975; age 29, died January 15, 1980. Dr. Glaser was a resident in dermatology at Presbyterian-University Hospital.

• **Earl Glotfelty,** Waynesboro; University of Pittsburgh School of Medicine, 1926; age 78, died December 22, 1979. Dr. Glotfelty practiced in Waynesboro for 50 years and was an honorary member on the staff of its hospital.

• **Norman Adam Hartman,** Pittsburgh; University of Pittsburgh School of Medicine, 1925; age 81, died January 1, 1980.

• **Jesse Kieffer,** Easton; Jefferson Medical College, 1933; age 74, died December 15, 1979.

• **Grover A. Meikle,** Galeton; Jefferson Medical College, 1922; age 85, died December 12, 1979. Dr. Meikle retired in 1977 after over 50 years of general practice.

• **Victor M. Reynolds,** Colwyn; Jefferson Medical College, 1905; age 97, died December 15, 1979. Dr. Reynolds practiced for 72 years in Darby.

• **David Stewart Polk,** Rosemont; University of Pennsylvania School of Medicine, 1927; age 78, died January 12, 1980. Dr. Polk practiced pediatrics in Rosemont for 48 years.

• **Charles Alexander Renick,** Pittsburgh; Harvard Medical School, 1936; age 69, died January 20, 1980.

• **Paul W. Riddles,** Bedford; Hahnemann Medical College, 1910; age 92, died March 8, 1979.

• **Paul C. Shoemaker,** Allentown; University of Pennsylvania School of Medicine, 1918; age 84, died December 21, 1979. Dr. Shoemaker practiced in Allentown for 48 years and was a past president of Lehigh County Medical Society.

• **Calvin W. Standen,** Mars; University of Toronto, 1924; age 81, died December 1979.

• **Frank J. Theuerkauf,** Erie; University of Maryland School of Medicine, 1924; age 80, died January 14, 1980. Dr. Theuerkauf practiced surgery in Erie for 43 years and founded the Tumor Clinic at Saint Vincent Health Center.

• **Edna Wilson Toovey,** Montreal, Canada; Medical College of Pennsylvania, 1943; age 75, died August 22, 1979.

**Joseph J. Buch,** Charleroi; Georgetown University School of Medicine, 1937; age 66, died December 12, 1979. Dr. Buch practiced in Charleroi for 40 years and was on the staff at Monongahela Valley Hospital.

**Sidney S. Goldman,** Philadelphia; Jefferson Medical College, 1926; age 77, died December 27, 1979. Dr. Goldman had been a district health center director for Philadelphia and had worked with the city's health department for 45 years.

**George Hibbs Hess,** Uniontown; University of Pennsylvania School of Medicine, 1911; age 93, died January 5, 1980. Dr. Hess established the x-ray department at Uniontown Hospital and was a past president of Fayette County Medical Society.

**Ralph Lynch, Sr.,** Fox Chapel; University of Pennsylvania School of Medicine, 1923; age 84, died January 25, 1980. Dr. Lynch was on the staff of Mercy Hospital and was an associate professor of medicine at the University of Pittsburgh.

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**DESCRIPTION:** Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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**Warnings:** As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

**Precautions:** If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

**Adverse Reactions:** Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

**Management of Overdosage:** Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

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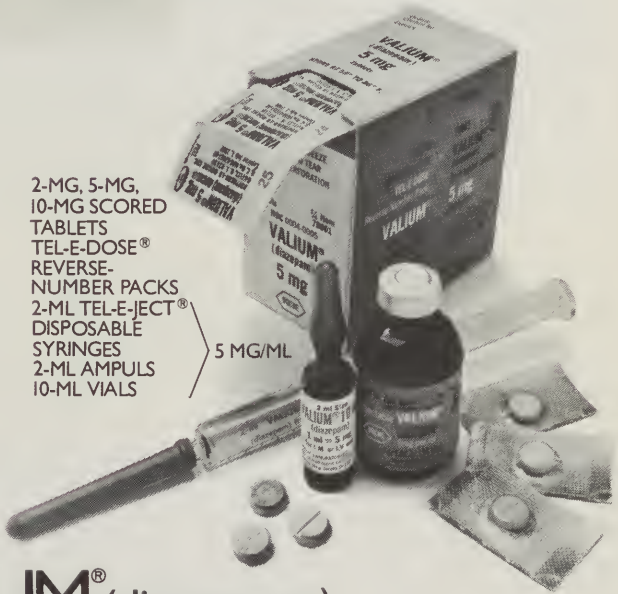


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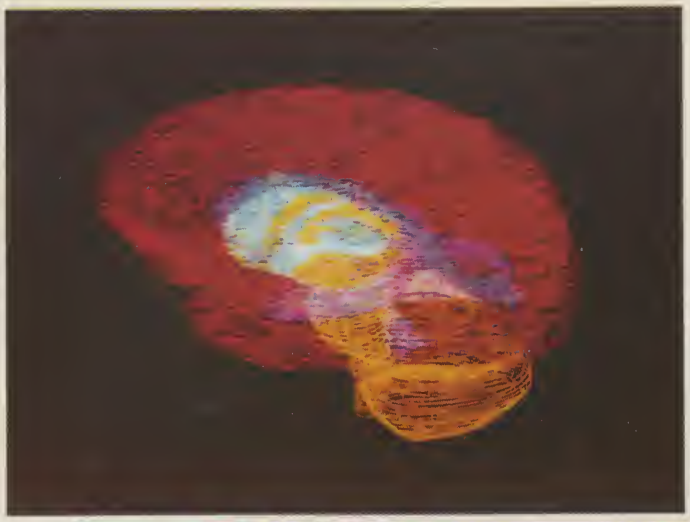

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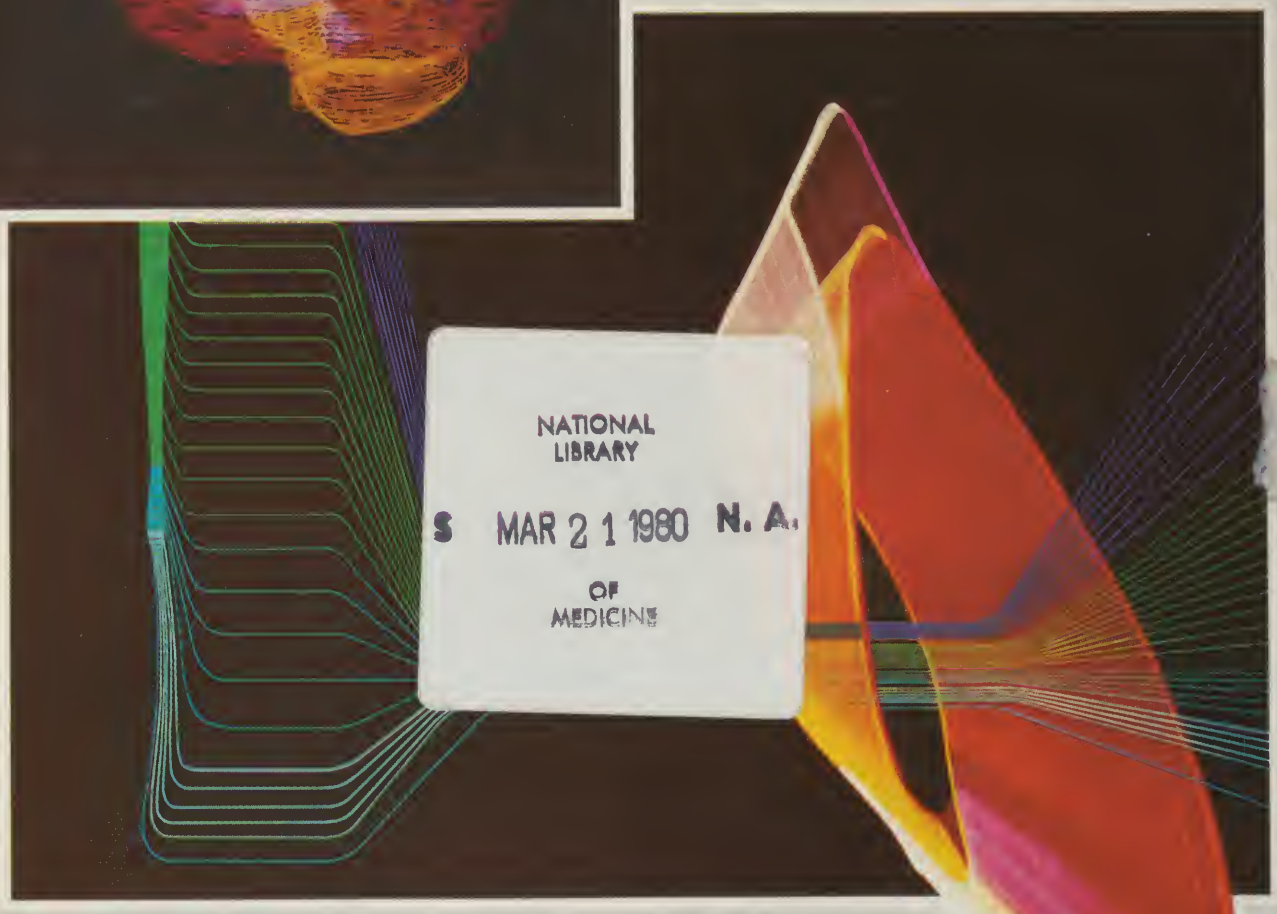

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# Pennsylvania Medicine

Vol. 83, No. 4 APRIL 1980

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DR. MARSHALL TESTIFIES ON MEDICAID REFORMS

Matthew Marshall, Jr., MD, PMS president, testified before the Pennsylvania Senate Appropriations Committee March 5. He said that the low fees paid to physicians were contributing to the high cost of the medical assistance program and creating two standards of care for sick Pennsylvanians. "It is estimated," he said, "that only 45 percent of Pennsylvania physicians participate in the medical assistance program because of extremely low fees...the medical assistance patient must use the more expensive hospital emergency room and outpatient clinic services." Dr. Marshall quoted a summary paper on medical assistance prepared by the Department of Public Welfare to offer solutions. These include encouraging "primary care in a private physician's office instead of in the hospital outpatient department or emergency room," and increasing "physicians' fees to encourage the use of private physicians...and discourage the use of the emergency room and outpatient department of the hospital."

HOUSE COMMITTEE STUDIES "MEDICAID MILLS" PROPOSAL

Robert S. Pressman, MD, Philadelphia, testified in Media March 6 when the House Health and Welfare Committee held a hearing on HB-2230, which would regulate "medicaid mills." Dr. Pressman, a PMS Board member, said the medical assistance program itself created an atmosphere in which "medicaid mills" could flourish. The Department of Public Welfare already has the power to control their activities, he said of the proposed legislation. Dr. Pressman synthesized the problems of the medical assistance program in a widely reprinted article which first appeared in Philadelphia Medicine and on page 26 of the February issue of this publication.

BLUE SHIELD BOARD REVISES PAYMENT ON MIDWIVES, PAs

Pennsylvania Blue Shield's Board of Directors voted February 6 to authorize payment to physicians for services provided by nurse midwives or physician assistants employed by and under the supervision of the physicians. Previously such services were compensated only if they were performed in the presence of and under the direct personal supervision of the physician. The new policy is expected to be implemented in May.

HEW SCHEDULES HEARINGS ON MEDICARE, MEDICAID

HEW's Health Care Financing Administration announced on March 19 a schedule of public hearings in 11 large cities across the nation in April, May, and June. The hearings on proposed regulations published March 7 in the Federal Register are scheduled for Philadelphia May 6 and 7. The regulations specify procedures by which hospitals, long-term care facilities, laboratories, and other providers of health services are certified to participate in medicare and medicaid programs.

ARBITRATION SYSTEM CHUGS ALONG SLOWLY

Of 3,127 claims filed with the Arbitration Panels for Health Care established under Act 111 of 1975, 772 have been settled, discontinued, or ended. A report issued this month and covering the period through February 29, 1980 also revealed that 795 conciliation conferences have been held. Of the 17 arbitration hearings held, seven awards have been appealed to Courts of Common Pleas. Claims still pending number 2,355. Of the 3,127 claims filed between April 5, 1976 and February 29, 1980, 40 percent (1,256) were filed in Philadelphia; 59 percent (1,840) were filed in the five county area of Bucks, Chester, Delaware, Montgomery, and Philadelphia; 15 percent (440) were filed in Allegheny County; and 26 percent originated elsewhere in the Commonwealth.

SOCIETY PUBLISHES GUIDE ON LIMITED PRACTITIONERS

The PMS Council on Education and Science has available a new publication, A Guide for Developing Bylaws Provisions for Hospitals for Credentialing Limited Health Practitioners. The author, Nathan Hershey, Esq., of Pittsburgh, prepared the book for PMS to answer an increasing number of questions about appropriate means to grant credentials to limited health practitioners. Single copies are free to PMS members; the charge to others is $5.00.

PMS HEADQUARTERS EXPANSION BEGINS

Construction for the addition to the PMS Headquarters in Lemoyne was started March 20. The $2.9 million project will double the office space and permit the Pennsylvania Medical Society Liability Insurance Company to locate permanently in the Headquarters. Construction is expected to be completed in the summer of 1981.

JAIL HEALTH TRAINING TOPIC FOR PMS SEMINAR

The State Society, as part of its Jail Health Program, will hold a seminar April 17 at the Penn Harris Motor Inn. More than 50 jail staff persons, county government officials, and county medical society representatives already are registered. The seminar will offer technical assistance on meeting AMA standards for health services in jails.

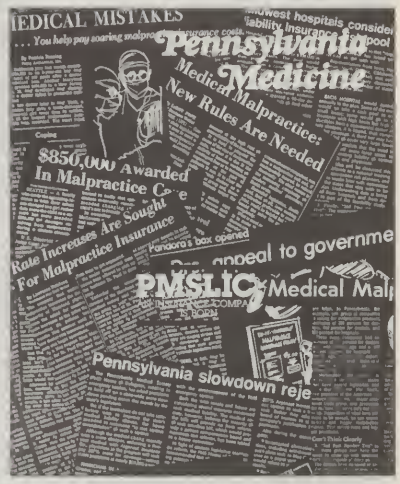
PMS WORKER'S COMPENSATION ANNUAL FIELD AUDIT DUE

Casualty Reciprocal Exchange, carrier for the Society's worker's compensation plan, will conduct its annual field audit during the next two months. Members who participate in the plan should have the necessary records available. In the past the audits have resulted in a 45 percent return of premiums to participating members.

HEW SETS SANCTION PROCESS FOR MEDICARE, MEDICAID

Final regulations published in the Federal Register February 20 establish procedures under which the Health Care Financing Administration (HCFA) may invoke sanctions against those who provide either excessive or poor quality care to hospitalized medicare and medicaid patients. HCFA has authority to exclude practitioners from the programs, either permanently or temporarily, or to assess a fine of up to $5,000. Under the regulations, first proposed for comment October 13, 1978, Professional Standards Review Organizations will report violations to HCFA and recommend sanctions. The regulations implement Section 1160 of the Social Security Act. See related article on page 26.

Pennsylvania Medicine

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20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

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Managing Editor
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Assistant Managing Editor

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**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

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# newsfronts

## New trustees join PMS policymaking body

Drs. J. Joseph Danyo and Robert S. Pressman are the newest members of the Society's Board of Trustees. These physicians, whose terms expire in 1982, were welcomed at the February 6 board meeting.

**Dr. Pressman**

Immediate past president of Philadelphia County Medical Society, Dr. Pressman represents the First District. He is an internist. He serves on the publication committee and as the board representative to the Council on Member Services.

Dr. Pressman is an associate professor of medicine at Temple University School of Medicine. His staff appointments include attending physician in preventive medicine and infectious disease at Albert Einstein Medical Center; consultant in infectious disease at Deborah Hospital; and physician in the internal medicine departments of Germantown, Rolling Hill, and John F. Kennedy Memorial hospitals.

A fellow of the American College of Physicians and the College of Physicians of Philadelphia, Dr. Pressman has held leadership positions in the Pennsylvania Society of Internal Medicine, PMS, and the Albert Einstein Medical Center.

He has presented four health related programs on television networks in Philadelphia and currently is a member of the community advisory board of WHYY-TV and WHUY-FM. Since 1969 he has been a member of Blue Shield Corporation. He also is on the board of the Community Home Health Services of Philadelphia.

**Dr. Danyo**

Dr. Danyo, an orthopedic surgeon from York, is councilor from the Fifth District. A member of the publication committee, he also is board representative to the Council on Health Planning and Facilities.

He graduated from the University of Scranton and received his medical degree from Jefferson Medical College in 1959. After completing his internship at Jefferson, he served as a lieutenant in the Navy from 1960 to 1962. In 1962 he returned to Jefferson and worked on his residency in orthopedic surgery. Dr. Danyo now is chief of orthopedics at York Hospital.

Dr. Danyo is vice chairman of the board of the Pennsylvania Medical Society Liability Insurance Company and a member of the board of directors of the Pennsylvania Medical Care Foundation. He is past chairman of the PMS Council on Medical Economics.

He is active locally as a member of the board of directors of Prepaid Health of York, and as medical director of York's Easter Seal Society. He is a past president of the York County Medical Society and also was active on the board of York's chamber of commerce.

From 1970 to 1972, Dr. Danyo served as the first president of the American Association of Hand Surgeons. He is a member of the American Academy of Orthopedic Surgeons, Eastern Orthopedic Society, American College of Sports Medicine, and a fellow of the American College of Surgeons.

### Preliminary Call to the 1980 Annual Meeting House of Delegates

The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Fairmont Hotel, Philadelphia, Pennsylvania on Friday, October 31, 1980. The second session will convene Saturday, November 1, 1980 and the third session Sunday, November 2, 1980. Details regarding the starting times of all three sessions will appear in the Official Call in the August 1980 issue of PENNSYLVANIA MEDICINE.

All proposed amendments to the Constitution must be submitted to the Office of the Secretary of this Society on or before June 30, 1980. Such amendments may be proposed upon the written petition of 15 Active, Senior/Active, Associate, or Intern/Resident members of the Society, or by the Committee on Constitution and Bylaws. Although there is no specific requirement that Bylaws amendments be submitted in advance or published in the Official Call, this is preferable when possible. Written resolutions to be considered by the House may be submitted to the Secretary by a delegate acting in his own behalf or for the component county medical society or specialty society he represents. If received prior to September 30, 1980, they will be published in the *Official Reports Book*.

G. Winfield Yarnall, MD
Secretary

Companion article on page 18

# PMSLIC — physician control makes the difference

**KathyLee Santangelo**

Physician input and physician control distinguish the Pennsylvania Medical Society Liability Insurance Company (PMSLIC).

Created with the financial help of every member of PMS, the company is unique among malpractice insurance carriers: it is the only Pennsylvania company of, by, and for physicians.

Today, just 16 months after the first of the 43-member staff was hired, some 5,500 physicians are secure in their PMSLIC coverage.

Today, PMSLIC offers advantages to all 14,500 PMS members—those physicians whose mandatory assessments funded the company. Returns on their investment, while intangible, are evident particularly in three areas—guarantee of insurance availability, risk management education, and PMSLIC's pledge to defend physicians against "nuisance" claims.

Today, PMSLIC works to improve the malpractice climate for all physicians in Pennsylvania, not just those it insures. PMSLIC generates the data and provides a mechanism to put the data to work when dealing with the legislature and regulatory agencies. The company exists not only to provide insurance but also as a reliable source for malpractice insurance statistics which never before have been available.

In just a year of inhouse operation, PMSLIC achieved some remarkable feats in the insurance industry. David S. Masland, MD, chairman of the PMSLIC board of directors, listed these in his report to the PMS House of Delegates last November:

- PMSLIC is holding the line on rates for 1980;
- PMSLIC reduced premiums for partnerships, corporations, and associations;
- PMSLIC reduced rates for part-time practitioners; and
- PMSLIC reduced rates for new physicians entering practice.

### Board trims cost

All PMSLIC policyholders will save dollars as a result of the board's vote to hold the line on rates for 1980. Despite double digit inflation, many physicians will be paying less for their PMSLIC insurance coverage in 1980 than they paid for their Argonaut coverage in 1977.

PMSLIC is the first malpractice carrier in Pennsylvania to eliminate charges for partnership, corporation and association liability coverage.

PMSLIC also is the only insurance company to reduce rates for part-time physicians. The company's board believed that the premiums for these practitioners were too high. PMSLIC corrected this inequity.

PMSLIC's board also implemented a 20 percent first year premium discount for physicians entering practices from residencies. The board based its action on a study which documented statistically that new physicians present lower risks than physicians who have been practicing for many years.

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*The PMS Board of Trustees renominated these PMSLIC board members at its meeting February 6 according to guidelines adopted by the PMS House of Delegates in 1977 and 1979 to assure PMS control.*

### Staff functions

A. John Smither, PMSLIC president and chief operating officer, augmented Dr. Masland's report to PMS with a history of PMSLIC's organization and operation. Smither assumed his present post on November 20, 1978. For seven years prior to this, as a senior vice president of Frank B. Hall & Co. of Pennsylvania, Inc., he was responsible for the daly administration of PMS's professional liability insurance program.

Smither is assisted by Ronald M. Bachman, vice president and marketing director. First employed by PMS in 1969 as assistant to the director of economic affairs, Bachman became director in 1974. He staffed the PMS Commission on Professional Liability Insurance from 1971 through 1978.

Bachman is responsible for effecting the steady, continuous growth of PMSLIC's portfolio to achieve the company's goal of providing professional liability insurance coverage to every qualified PMS member. Through advertising, direct mail campaigns, and personal visits to physician groups, he has introduced PMSLIC to every potential insured.

### Physician involvement

Recruitment of a complete, professional staff occurred early. "But this group of professionals," Smither said, "cannot fulfill PMSLIC's objectives without the help of the physician board and committee members. *Medical* knowledge and *physician* evaluation of specific risk exposures led to the many premium reductions and the innovations reported by Dr. Masland.

"In underwriting, our goal is to ensure a correlation between the premium charged and the exposure evidenced by actual claims experience. Through the combined expertise of our physicians and staff in this area, we have met the intent of the PMS House of Delegates that PMSLIC be physician-oriented and fully responsive to

David S. Masland, MD

Ronald M. Bachman, reporting to PMSLIC board

January meeting of PMSLIC board

the needs of all segments of the medical fraternity."

**Loss prevention**

Risk management is an insurance company function by Insurance Department Regulation. PMSLIC has a risk management committee under the chairmanship of J. Joseph Danyo, MD, vice chairman of the PMSLIC board. Judith Brown, R.N., J.D., director of risk management and loss prevention, is working with the committee to develop a program of malpractice risk control that physicians can use in their daily practices. She is editor of *PRN*, a risk management/loss prevention newsletter. *PRN* is circulated to all PMS members to alert them to the continual importance of quality patient care and to effective control of potential malpractice situations.

Ms. Brown sees the newsletter as filling a void in physician education. As an additional, more formal teaching tool, PMSLIC plans to offer its first medical-legal correspondence course. Working with the risk management committee, she coordinated the program and faculty and said that PMSLIC will pay for the cost of the eight-hour course which will earn Category 1 continuing medical education credit.

Judith Brown

Anna Laverture

Roger Roggenbaum

Karl Detweiler, director of underwriting

**Claims handling**

"Without question a sensitive area is handling and resolving claims or suits alleging malpractice," Smither said. "Unlike commercial carriers, PMSLIC is pledged to defend physicians against non-meritorious claims. We don't let economic considerations determine how a claim will be resolved. PMSLIC will not concede negligence where none exists."

Roger Roggenbaum, claims department manager, reported that this policy already has resulted in four discontinued cases. Realizing that their "nuisance" claims would not trigger a token settlement, plaintiffs have dropped their cases.

PMSLIC's board hopes that this policy will affect the plaintiff's bar. The board members believe that as PMSLIC demonstrates its commitment to fight non-meritorious claims, lawyers will discourage "nuisance" claims. Roggenbaum explained, "This goal cannot be achieved until PMSLIC goes through the arbitration panel and trial procedure. Only then can our company convince the plaintiff's bar of its total commitment to its insureds."

On the other hand, PMSLIC is committed to moving quickly to settle meritorious claims as equitably as possible. PMSLIC's claims committee, including six PMSLIC board members and staff, meets at least one full day each month.

The claims committee determines how a case should be handled based on the results of the claims department's investigations. The company presents its decision to the physician insured. If the company and the insured reach an impasse on how a claim should be settled, the matter is referred to the PMS Commission on Professional Liability Insurance for a binding resolution.

The claims committee has the additional task of appointing defense attorneys. Before any defense attorney is approved, the committee conducts a thorough investigation. Linda Lichtman, Esq., PMSLIC's general counsel and secretary, is involved in these activities on a daily basis.

**Data processing and research**

In the domain of data processing and research, the company also displays its physician orientation. Larry Smarr, director of data processing and research, said, "Instead of the arbitrary tabulations of commercial carriers, PMSLIC's data processing and research are tailored to its physician insureds. For example, our data system is programmed to anaylze classification and territorial rate relativities by major specialty category and by medical procedure. The consulting actuary assists the underwriting and risk management departments in the analysis which ensures that our overall rate level and underwriting posture reflect the realities of its ongoing experiences."

**Questions and complaints**

PMSLIC's philosophy is that it must be foremost in representing the interests of physicians in private practice. This is especially evident in the professional affairs department. Anna Lavertue, director of professional affairs, handles physician inquiries and complaints. She explained, "We try to fulfill each request as quickly as we can. Although this means we spend a lot of time on the phone, we consider it worthwhile if the physician is satisfied by the end of the conversation."

**Excellence is goal**

All PMSLIC staff members put the needs of the physician policyholders first. Smither provides a model for them by his demand for excellence in serving the profession. He said, "I make no bones about it. To me physicians are special people and I believe that this feeling is shared by my staff and is reflected in the manner in which they perform their tasks."

PMSLIC benchmarks are physician involvement, professional staff, and a philosophy of excellence and integrity. It is an exclusive company for physicians who demand the best.


## Continuing Medical Education Programs
## The Milton S. Hershey Medical Center
## The Pennsylvania State University

1. *End Stage Renal Disease: Patient Care Planning/April 24 & 25, 1980
2. Career Planning for Resident Physicians/April 25 - 26, 1980/Meadows, Hershey, PA
3. *Management of Radiation Hazards for Emergency and Primary Care Physicians/April 25 & 26, 1980
4. *Family Practice Review/April 28-May 2, 1980
5. *Adolescent Sexuality/May 2 & 3, 1980
6. *Personal Financial Planning for Physicians/May 14, 1980
7. *Child Abuse '80/May 22 & 23, 1980
8. A System for Managing the Individual with Spinal Cord Injury/May 23, 1980/Hershey Motor Lodge
9. Special Care for Children—A Symposium/June 4 & 5, 1980/Hershey Motor Lodge
10. *Human Sexuality and the Aging/June 13, 1980

*Treadway Resort Inn, Grantville, PA

**For further details contact:**
**Continuing Education, Department 4005**
**500 University Drive, Hershey, PA 17033**
**(717) 534-6032**

# How 123 new doctors saved $100,000 in professional liability premiums

They did it last year by taking advantage of PMSLIC's 20% discount on professional liability insurance premiums to all new insureds entering practice in Pennsylvania for the first time.

That's right! A big 20% discount and you still get the same, complete coverage. That's an important saving for new doctors coping with so many other start-up expenses.

Find out more about Pennsylvania's only doctor-owned and directed insurance carrier and how our "zero-profit" philosophy can save you money. Send for more information.

**Pennsylvania Medical Society Liability Insurance Company**

**PMSLIC®**

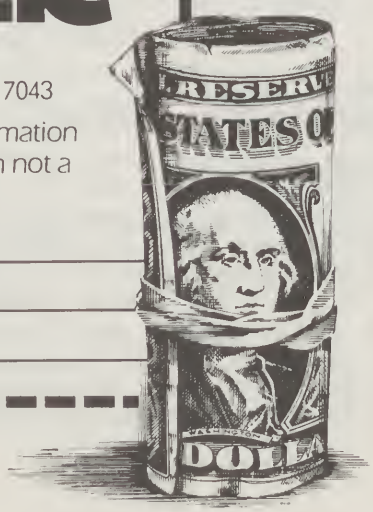
P.O. Box 303 • Lemoyne, Pa. 17043

Please send me more information on PMSLIC. I ☐ am ☐ am not a new doctor.

Name _____

Address _____

_____



# State introduces Child Health Passport

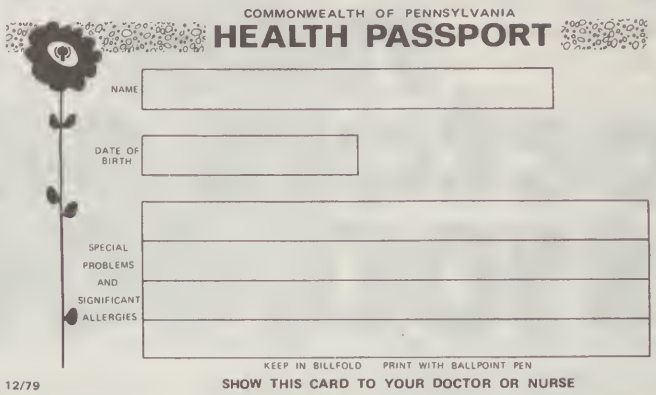
A new state personal immunization record, the Child Health Passport, will be available for distribution beginning April 17, 1980.

The passport was developed by the Pennsylvania Committee for the International Year of the Child. It is a wallet-size card of plasticized paper designed to resist wear and tear.

The front of the card has space for the child's name, birthdate, special problems, and allergies. The back lists the childhood diseases and the suggested ages when the child should receive immunization against them. After each listing is a space where the date of immunization can be recorded.

The PMS House of Delegates in November adopted a resolution urging all physicians who treat children to consider using the passport in their practices. In response to the House's action, the State Society has mailed an initial supply of the cards to family physicians, general practitioners, and pediatricians.

The cards also may be obtained at Department of Health district offices and most state health centers.



COMMONWEALTH OF PENNSYLVANIA

**HEALTH PASSPORT**

NAME

DATE OF BIRTH

SPECIAL PROBLEMS AND SIGNIFICANT ALLERGIES

KEEP IN BILLFOLD PRINT WITH BALLPOINT PEN

12/79

SHOW THIS CARD TO YOUR DOCTOR OR NURSE

All Schedules Are Suggested

| DTP: Diphtheria - Tetanus - Pertussis | DATE |
|---|---|
| 1st (2 mos.) | |
| 2nd (4 mos.) | |
| 3rd (6 mos.) | |
| Booster (18 mos.) | |
| Booster (4-6 yrs.) | |

| Td: Tetanus Diphtheria | DATE |
|---|---|
| Booster (14 yrs) | |
| Booster | |
| Booster | |

| Measles (15 mos. or older) |
|---|
| Mumps (15 mos. or older) |
| Rubella (15 mos. or older) |

| Trivalent Oral Polio Vaccine | DATE |
|---|---|
| 1st (2 mos.) | |
| 2nd (4 mos.) | |
| 3rd (18 mos.) | |
| 4th (4-6 yrs.) | |

| Other |
|---|
| |
| |
| |
| |

| At one year: Then as indicated | Date | Tuberculin Tests | Result |
|---|---|---|---|
| | | | |

PENNSYLVANIA CHAPTER
◆
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

**PaACEP Annual Meeting — June 12, 1980**

**PaACEP Annual Scientific Assembly — June 13, 14, 1980**

MARRIOTT HOTEL
City Line and Monument Avenue
Philadelphia, Pennsylvania

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**Emergency Department Procedures**

Application has been made for 14 hours of ACEP Category I credit.

A display of commercial and scientific exhibits will be available during course hours.

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# Court rules right of privacy not absolute

**Fred Speaker, Esq.**

Despite a patient's constitutional right of privacy, a psychiatrist is entitled to testify without the patient's consent in a proceeding for involuntary commitment. So held the Pennsylvania Superior Court in *Commonwealth ex rel. Platt v. Platt.*[1]

In the *Platt* case a woman was committed to a hospital for involuntary emergency psychiatric treatment on petition by her husband. Pursuant to statute,[2] a hearing was held four days later, and thereafter she was certified for extended involuntary treatment for the maximum period. The wife appealed, contending among other claims that the testimony of her physician without her consent should have been barred.

The Superior Court held that the statutory grant of the patient-physician privilege[3] was not applicable because the Pennsylvania Supreme Court had determined that:

> "Whatever the meaning of loathsome disease, psychiatric treatment does not evidence the existence of such a condition." *In re "B", Appeal of Dr. Loren Roth,* 482 Pa. 471, 394 A.2d 419 (1978). Since psychiatric treatment does not evidence the existence of a loathsome disease, evidence of such treatment could not blacken the reputation of one who has sought it for only evidence of such a disease would tend to blacken a person's reputation.[4]

Noting that the statute required the testimony of the treating physician,[5] the Superior Court found that:

> The requirement of testimony of the treating physician is also the strongest guarantee that a spouse will not act in bad faith in attempting to commit a spouse for treatment who does not require it. Appellant [wife] would have us bar the testimony of the two people who are in the best position to detect and observe a person's mental disability, *i.e.* the person's spouse and the person's doctor. Such a result would be ludicrous and would defeat the obvious legislative purpose of the Act.[6]

Faced with the holding of the *Roth* case that the patient had a constitutional right of privacy prohibiting the testimony of her psychiatrist without her consent, the Superior Court said that "the right of privacy, like every other right, is not absolute,"[7] and pointed out that in *Platt,* unlike *Roth,* there was a statute involved.

The Superior Court concluded by saying:

> After all it is the psychiatrist who has the training and expertise to determine a person's mental condition. As stated above, it is the psychiatrist whose testimony stands between the patient and an unscrupulous spouse who attempts to commit a person who is not in need of treatment. Were we to hold that a patient could exclude his psychiatrist's testimony in an involuntary commitment proceeding on the grounds of his right to privacy we would effectively be "wiping such proceedings off the books" or else placing these important issues into the hands of laymen who are generally ill-equipped to render opinions or even observations relative to the person's mental state. Needless to say this would serve neither the interests of the patient nor society which has an interest in seeing to it that those of its members in need of treatment for mental disabilities obtain it. This we refuse to do and therefore hold that in this case the patient's right to privacy must give way to the interests of society in having that person treated.[8]

An unfortunate result of the *Platt* decision already has been manifested in the 1980 decision of *Commonwealth v. McKay.*[9] That county court case involved an appeal by a motorist from an administrative decision to recall her operator's license because she had a drug dependence.

The motorist objected to allowing her former psychiatrist to testify at the hearing. She had gone voluntarily to a state hospital for a psychiatric consultation and was interviewed by two psychiatrists. Her condition was diagnosed as "drug dependence."

The director of the hospital, in compliance with Vehicle Code provisions,[10] reported the diagnosis to the Department of Transportation. The motorist objected, relying on *In re "B";* but the court held that the *Platt* decision was controlling.

Thus the courts continue to sketch the context in which the patient's right of privacy is to be placed.

1./ 404 A.2d 410 (Pa. Super. 1979).
2./ Mental Health Procedures Act, 50 P.S. §§7101 *et seq.*
3./ 28 P.S. §328.
4./ *Commonwealth ex rel. Platt v. Platt, supra* at 415.
5./ 50 P.S. §7303(c).
6./ *Commonwealth ex rel Platt v. Platt, supra* at 416.
7./ *Ibid.* See also articles in PENNSYLVANIA MEDICINE at p. 17 (October 1979); p. 13 (February 1979); and p. 15 (October 1977).
8./ *Id.* at 417.
9./ 28 Ches. Co. Rep. (1980).
10./ (b) Reports by medical personnel.-All physicians and other persons authorized to diagnose or treat disorders and disabilities defined by the Medical Advisory Board shall report to the department, in writing, the full name, date of birth, and address of every person over 15 years of age diagnosed as having any specified disorder or disability within ten days.
(c) Responsibility of institution heads.-The person in charge of every mental hospital, institution, or clinic, or any alcohol or drug treatment facility, shall be responsible to assure that reports are filed in accordance with subsection (b). 75 Pa. C.S. §1518.

## Pediatricians study at national seminar

The American Academy of Pediatrics will host its Spring Session April 19-24 at the Las Vegas Hilton, Las Vegas, Nevada. The session will feature child health care specialists discussing such topics as child abuse, legal issues in pediatric and adolescent medicine, learning disorders, growth and development, breast feeding, and sports medicine.

The meeting will open Saturday and Sunday with a full program of 15 one-day seminars providing education on nutrition of the low birth weight infant, pediatric allergies, care of the newborn, epilepsy in childhood, infectious diseases, and pediatric dermatology.

Plenary sessions to be held Monday through Thursday will offer presentations on the latest developments in neonatal seizures, hypoglycemia, chronic cough, newer antibiotics, bone marrow transplantations in children, and adolescent homosexuality.

Round tables, scientific presentations and exhibits, and a council on pediatric practice complete the program.

## Awards, entertainment highlight dinner

# Secretaries of health, welfare at 1980 Officers' Conference

Helen O'Bannon, secretary of the state's public welfare department, and H. Arnold Muller, MD, secretary of the health department, will address the PMS 1980 Officers' Conference set for April 23 and 24 at the Penn Harris Motor Inn, Camp Hill.

Secretary O'Bannon will welcome the participants with a special report on the welfare department's medical assistance program. Dr. Muller will present an update on health care in the state.

For a national perspective, participants will hear from Hoyt D. Gardner, MD, president of the American Medical Association. Dr. Gardner will discuss the AMA's current activities.

Other programs for Wednesday afternoon include a panel discussion on who has the power in a hospital, a multi-media show on the physician leaders of organized medicine, and a report on political action by Michael P. Levis, MD, chairman, American Medical Political Action Committee.

The dinner meeting Wednesday evening, will feature Ferdie Pacheco, MD, author and humorist. Dr. Pacheco's remarks are titled "You are the champion."

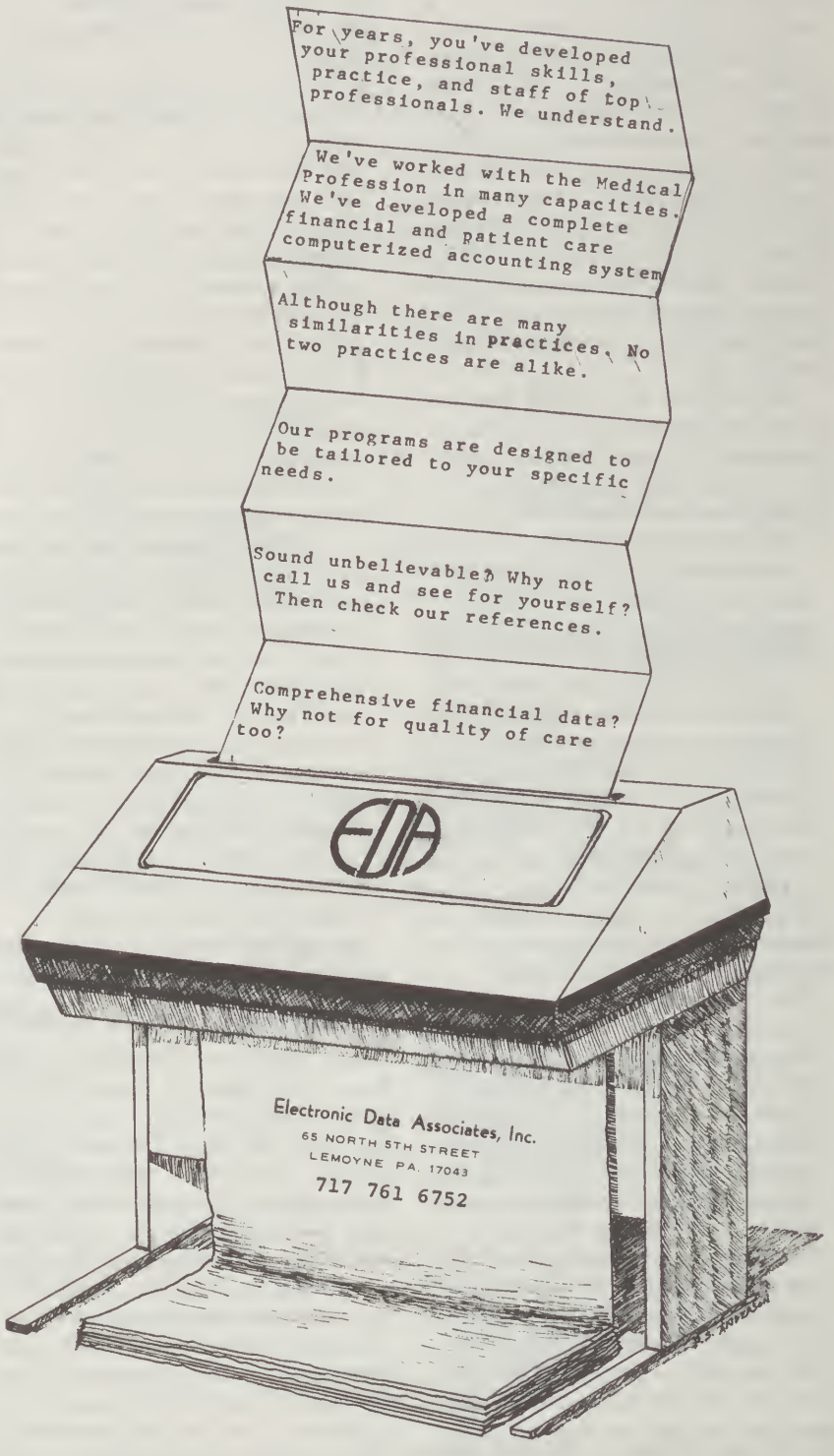
At the dinner, the Society will present three Environmental Improvement Awards and two Benjamin Rush Awards.

Raymond D. Shaffer and the late Mark N. Whitmer both will receive the individual Environmental Improvement Award. The recipient of the voluntary agency award is Camp Kon-O-Kwee of Fombell. The Runners Act to Clean Environment (RACE) of State College is the recipient in the community category.

Hy Horowitz, a volunteer at the Veterans Administration Clinic in Butler, will receive the individual Benjamin Rush Award. The recipient of the organization award is the Pittsburgh Pinch Hitters, a group of baseball players' wives.

Thursday morning's session will begin with a prayer breakfast by Jay W. MacMoran, MD, chairman of the PMS Commission on Medicine, Religion, and Bioethics. After the prayer breakfast, Tim Lee Carter, MD, will present the Donaldson Memorial Lecture. Dr. Carter is one of two physicians in the U.S. Congress.

As a conclusion to the conference activities, Kevin Phillips, president of the American Political Research Corporation, will comment on the 1980 national elections.



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# Medicare regulation change editorial, not substantive

*James H. Sammons, MD, executive vice president of the American Medical Association, issued this statement following wide press coverage of an HEW release on a revision of the medicare waiver of liability regulations. The HEW release indicated that in certain cases a physician might be held liable for charges for services not covered by medicare unless written notice of noncoverage was provided to patients by the physician. Dr. Sammons' statement, reprinted here, explains the regulation.*

On November 29, 1979 the Health Care Financing Administration (HCFA) published in the *Federal Register* a revision of earlier regulations which dealt with "waiver of liability" for medicare beneficiaries. The regulation was intended to clarify existing policy, not to change it. However, the HEW press release accompanying the change and the newspaper reports concerning it have led to widespread misunderstanding of the regulation's impact.

The newspaper stories gave the impression that medicare beneficiaries did not have to pay for *any* service not covered by medicare unless their doctors gave them written notice in advance that the program would not pay for the service.

This is not an accurate statement of the regulation's content.

Medicare law (Section 1879) provides that when a beneficiary receives care and a claim is submitted and paid by the program for services later determined to be either medically unnecessary or custodial, patient liability for the amount thus overpaid will be waived if the patient did not know the service was not covered.

Regulations pertaining to this section, published in January 1975, stated that the patient would be presumed not to know about such exclusions in the absence of evidence to the contrary. Such evidence would "include (but not be limited to)" written notice in advance from three sources: the intermediary or carrier, a utilization review committee, or the provider (hospital, skilled nursing facility, or home health agency), or "other person furnishing such items or services to the individual," or a written notice from one of these sources on a similar prior claim.

The November 29, 1979, change in regulations was issued because administrative law judges had ruled that the parenthetical phrase quoted above—"(but not be limited to)"—would recognize an *oral* notice to the patient as meeting the regulatory requirement.

The *only* change made by the November 29 regulations in rules which have been in effect since January 1975 is to limit the evidence of patient knowledge to *written* statements from the three sources listed, either in regard to the current claim or in regard to a similar prior claim.

No other change, except purely editorial, was made in the regulations. *No substantive new obligation is placed on physicians by this regulation.*

Despite the news stories, the regulation makes no real change in physician-medicare relationships. The law (Section 1879) applies to physicians only on claims for which they have accepted assignment, and the only situation in which medicare would recover from the *physician* any amount paid by the patient would require:

1. that the physician accept assignment on the claim;
2. that he collect from the patient some portion of his charge over and above the deductible and coinsurance;
3. that medicare pays the claim and then finds that the service is either medically unnecessary or custodial; and
4. that the physician knew the claim would be considered medically unnecessary or custodial when he filed it.

Since current regulations presume that the physician, like the patient, is not aware that the service is not covered in the absence of evidence to the contrary—primarily a notice from carriers or intermediaries or from a utilization review committee to the physician—such a combination of circumstances would be extremely rare.

*There is no provision either in this section of the law or in the pertinent regulation whereby any amount can be recovered from a physician as a medicare overpayment unless medicare has first paid that amount to the physician on an assigned claim.*

Under both the November 29, 1979, regulation and the January 1975 regulation, *the major responsibility for written notices rests with intermediaries or carriers, with utilization review committees, and with providers,* not with physicians.

"Physicians" are not even specifically named in the regulation. They are included only as an alternative to "providers," as "other person furnishing the items or services to the individual"—which limits the *admissibility* of a written notice from a physician to services he has himself furnished.

## Notice

The *Pennsylvania Law Journal* is hereby authorized to publish Opinions of the Administrator for Arbitration Panels for Health Care. Citations to the *Pennsylvania Law Journal* publication of an Opinion may be used in all memoranda of law and other appropriate legal papers filed with the Office of the Administrator for Arbitration Panels for Health Care. Without prejudice to any other mode of citation, an Opinion published in the *Pennsylvania Law Journal* may be cited by the name and docket number of the case, date of the Opinion and the volume, issue and page number of the *Pennsylvania Law Journal.*

Arthur S. Frankston, Esq.
Administrator
Feb. 11, 1980

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DISCUSSING LEGAL ALTERNATIVES TO I.R.S. 1041

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JAMES G. BRYAN, Management Consultant and Founder of Doctors Management Consultants, Portland, Oregon, has served the medical/dental profession for many years. A teacher, lecturer, and economist, James Bryan earned his degree at the University of Oregon. He is a recognized authority on Off-Shore Tax Planning, Medical Malpractice Insurance and Tax Straddles.

CARL J. SAVIO, Financial Planning expert and President of Coordinated Professional Services, Philadelphia, Pa., specializes in International Estate Planning, Insurance Options and Tax Havens. An innovator, Savio combines his experience in International Tax Law, Accounting and Business Management to develop sound tax reduction plans for professionals and corporations.

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U.S. TAX PLANNING CORPORATION

# physicians in the news

**D. Ernest Witt, MD,** recently was appointed chairman of the publication committee of the American Academy of Family Physicians. Dr. Witt is speaker of the PMS House of Delegates and coroner for Columbia County.

**John B. Jacobs, MD,** has been elected chairman of the Montgomery County Community College Board of Trustees. Dr. Jacobs is a retired general practitioner who served on the board for the past 10 years.

**Richard J. Miraglia, MD, PhD,** has been named to the Primary Care Editorial Board of *Diagnosis,* a publication of the Medical Economics Company. Dr. Miraglia is secretary treasurer of the Northeastern Counties Chapter of the Pennsylvania Academy of Family Practice.

**Bangalore V. Suryanarayana, MD,** recently was elected a fellow of the Royal College of Physicians, Edinburgh, United Kingdom. He is an active attending physician at Chestnut Hill and Graduate hospitals, Philadelphia.

**Howard E. Morgan, MD,** recently received the American Heart Association's top volunteer award. Dr. Morgan is Evan Pugh professor and chairman of the physiology department and associate dean of research at Hershey Medical Center.

At its recent meeting the PMS board of trustees commended **Rosario Maniglia, MD,** for his service to the Pennsylvania Medical Society and the Specialty Societies. Dr. Maniglia, a Dauphin County pathologist, is past chairman of the Interspecialty Committee.

**William Buchheit, MD,** recently was elected president of the Pennsylvania Neurosurgical Society. He succeeds **Robert Selker, MD.** Other officers elected for 1980 are **David A. Tilly, MD,** president elect and **William A. Black, Jr., MD,** secretary treasurer.

At its February meeting, the PMS Board of Trustees nominated **George P. Rosemond, MD,** for the AMA's Sheen Award. Dr. Rosemond is president of the College of Physicians of Philadelphia and past president of PMS.

**Louis Jaffe, MD,** has been appointed surgeon of the Department of Pennsylvania Jewish War Veterans. Dr. Jaffe, a dermatologist, has practiced medicine in Pottstown for 28 years.

DR. REX

DR. NORRIS

**Eugene B. Rex, MD, president of the Pennsylvania Academy of Ophthalmology and Otolaryngology, will host Charles M. Norris, MD, at the Academy's annual meeting May 21-24 in Bedford. Dr. Norris is professor and chairman of the laryngology and bronchoesophagology department at Temple University School of Medicine.**

**Gary Haverty, DO,** has been elected to the board of directors of the Central Pennsylvania Health Systems Agency. Dr. Haverty, pathologist at Punxsutawney Area Hospital, will represent Jefferson County.

**Donald W. Hess, MD,** has been appointed medical director of the West Branch Drug and Alcohol Abuse Commission. Dr. Hess is a Williamsport family practice physician.

Pennsylvania State University presented its distinguished alumni award to **Kenneth Weston, MD.** Dr. Weston is a surgeon and emeritus chief of orthopedics at Allentown Hospital.

Franklin Chamber of Commerce honored **Edith Sechler, MD,** with its Woman of the Year award. Dr. Sechler is a physician and administrator at Polk Center.

The Region III office of Health, Education, and Welfare named **Jack Gold, MD,** the recipient of its International Year of the Child award. Dr. Gold is pediatric consultant at the Sarah Reed Children's Center and chief of pediatrics at Saint Vincent Health Center.

**Michael Rhodes, MD,** has been named to the Medical Scientific Advisory Board of the Pennsylvania Regional Tissue and Transplant Bank. Dr. Rhodes is trauma coordinator in the surgery department at Sacred Heart Hospital, Allentown.

What penicillin failed to do for elderly victims of pneumonia provoked **Robert C. Austrian, MD,** to develop a new pneumococcal vaccine. The trustees of the Philadelphia Award recognized this contribution to the community by naming Dr. Austrian the recipient of its 1979 $15,000 award.

Dr. Austrian is professor and chairman of the research medicine department at the University of Pennsylvania School of Medicine.

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From 'bedpan mutuals' to respected solidarity

# Physician-owned malpractice insurance companies

A. John Smither

To understand and appreciate the recent phenomenon of the physician-owned and directed malpractice insurance companies, the "bedpan mutuals" as they were disparagingly referred to by industry traditionalists, one should review the years from 1967 to 1977. This period of time truly was a decade of crisis for doctors, insurance companies, and lawyers.

**History**

Zeroing in on the years from 1967 to 1971 the crisis was one of availability. In 1967, the established commercial carriers were literally tripping over themselves to abandon the professional liability insurance line. The market dropped from a peak of over 100 companies nationwide to fewer than 12. The key companies remaining on the market were St. Paul, Aetna, CNA, Hartford, INA, Argonaut, and Medical Protective.

To the extent that a license to practice medicine and the ability to secure adequate malpractice insurance went hand in hand, the crisis of availability affected the medical practitioner far more than the insurance industry or the legal profession.

From 1971 to 1975, the crisis shifted to one of affordability. With the exception of Medical Protective, the companies remaining in the medical malpractice field were wedded to the medical society sponsored/group underwriting concept. In those jurisdictions where the state medical societies joined forces with a carrier to provide professional liability insurance as a society membership benefit, coverage once again became available. A number of advantages accrued to both the physicians and the companies.

Underwriting standards were generally more physician-oriented and equitable, with varying degrees of physician participation. The medical society by agreement with the company was able to act as the physicians' ombudsman in underwriting and claims-handling disputes. Joint efforts implemented previously neglected risk management/loss prevention techniques.

The companies enjoyed a broad spread of risk by specialty and territory. Acquisition costs were reduced by using exclusive brokers of record who, doubling as program administrators, were charged with certain production, policywriting, and underwriting functions previously handled by the companies. Of course, the enormous premium cash flows generated by these statewide programs added substantially to the investment income of the participating companies.

Initially, competition for society-sponsored group programs was intense enough to spawn "loss leader" rate levels. As the various groups began to assimilate credible loss statistics, however, "jumbo" rate increases became the rule rather than the exception.

In Pennsylvania during the years 1974 to 1977 premiums increased 569 percent under the program sponsored by the Pennsylvania Medical Society and underwritten by Argonaut.

Almost without warning, the second company exodus from the medical malpractice market began deserting many doctors in programs sponsored by state medical societies. By then, the insurance companies shared the crisis with the doctors.

From 1975 to 1977, the crisis became one of urgent medical/legal reform. Legislative activity dominated in almost every state. The fact is that much legislation was enacted despite the opposition of the plaintiffs' bar, and with little support from the insurance industry.

Although legislative reform varied by state, a common thread did emerge. Insurance availability was guaranteed by establishing the Joint Underwriting Associations. Catastrophe Loss Funds providing coverage layers at limits in excess of the minimum insurance amounts were mandated by law as a condition of licensing. Mechanisms for mandatory and binding arbitrations were established in an effort to speed the resolution of malpractice claims.

The various statutes of limitations affecting the rights of patients and the liabilities of the companies were amended. Most legislation sought to empower the state licensing laws with policing and censuring problem physicians. By the time the decade in ques-

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*Mr. Smither is president and chief operating officer of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC). This article is excerpted from Mr. Smither's remarks on physician-owned and directed malpractice insurance companies. His remarks were delivered at the Nineteenth International Conference on Legal Medicine sponsored by the American College of Legal Medicine in May 1979.*

tion ended, the doctors, the insurance industry, and the legal profession shared the crisis equally.

Inevitably, any time span marked by upheaval, whatever the nature, is tagged for easy identification, and mentally I have classified 1975 to 1979 as the "fallout" years. Crisis upon crisis had brought the medical malpractice insurance system almost to the "meltdown" phase and in a meltdown, fallout is inevitable. Unlike the fallout of our recent nuclear crisis, the fallout of the medical malpractice insurance crisis was both constructive and healing.

The major ingredient of the malpractice fallout was the physician-owned and operated malpractice insurance company concept. The fallout first appeared in Maryland in June 1975, and spread that same year to Michigan, California, New York, New Mexico, North Carolina, and Tennessee.

Today there are 21 physician-owned, state medical society created, professional liability insurance companies located in 19 states (California typically has three separate companies). Among them they insure over 84,000 practicing physicians. Similar companies created without medical society blessing cover more than 8,000 additional physicians.

**Neophyte organizations**

The largest new company is in New York state. Currently it insures approximately 18,000 policyholders. The smallest company is located in Maine and it insures a mere 425 policyholders.

Three companies in other states each currently insures fewer than 1,000 policyholders. As an ex-state regulatory official, I am uneasy that companies have been chartered and have been given the regulatory go-ahead to write such minuscule portfolios in a line as volatile as medical malpractice.

Ten of the companies offer "occurrence" type coverage only, and seven offer "claims-made" policies only. Four companies, including PMSLIC, offer both "occurrence" and "claims-made" coverage. This allows individual insureds to choose their coverage.

Any comparison of company premium ranges or average premiums would be useless because of the varying limits of liability and types of available coverage. Companies which offered the "claims-made" coverage where previously only "occurrence" coverage had been available were able to effect instant premium reductions. This reflects the traditional way of setting first-year "claims-made" premiums as a percentage of the current "occurrence" premiums.

Capital and surplus amounts also run the gamut from the New York company's $44 million to $1.1 million held by companies operating in Maine and in North Carolina. Again, comparisons between the companies in this regard are worthless unless one also compares the extent of their liability at risk and their surplus to premiums written ratios.

Initially the sponsoring state medical societies generally adopted conservative capitalization and surplus positions. The maximum liability at risk by company runs from a high of $2 million per claim/$4 million annual aggregate (subject to reinsurance ceded) to a low of $100,000 per claim/$300,000 annual aggregate.

Effective January 1976 in Pennsylvania, the medical malpractice reform legislation limits a company's liability to $100,000 per claim/$300,000 annual aggregate. This is augmented by a state-run Catastrophe Loss Fund which provides an additional $1 million layer of coverage for each subscriber. All licensed practicing physicians must subscribe.

A company's liability is limited further by the same statute to four years from the date that the services were rendered out of which a claim or suit alleging malpractice arises. Claims or suits which emerge more than four years after the date the services were rendered become the responsibility of the Catastrophe Loss Fund.

Pennsylvania's legislative reform established relatively benign limits within which to capitalize and operate a medical malpractice company. The liability ceiling of $100,000/$300,000 represents an affordable retention level and makes it unnecessary to purchase reinsurance, an expensive outlay given today's inflated-to-capacity market.

Out of these independent ventures into insurance a trade association known as the Physician Insurers Association of America (PIAA) has emerged. Its past activities indicate that PIAA provides a responsible forum for the regular exchange of ideas, premium and loss statistics, management and technical information among like companies, with minimum income expectations and expenses to match. As a member company representative, I will be content to see the PIAA continue to exist and flourish within the modest framework envisioned by its founders.

**PMSLIC**

The Pennsylvania Medical Society Liability Insurance Company, or PMSLIC as it is known in the trade, is the physician-owned company that is sponsored by PMS. Its management/operating philosophy basically reflects most physician-owned and operated insurance companies.

First, we try not to lose sight of the fact that PMSLIC was created as a not for profit organization. The company received its initial $150,000 capi-

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talization amount directly from the Pennsylvania Medical Society. Physician members of PMS contributed an additional sum to surplus of almost $9 million.

Although we do not want PMSLIC to be run in the red, we are committed to return any operating gains to our policyholders promptly in the form of reduced rates. We are committed to using the lowest rate level actuarially possible within prudent business practices. We are committed to providing physician input into all company policy, underwriting, and claims-handling decisions.

We are committed to defending all claims that appear to be without merit. This is an important departure from most commercial carriers which, having been formed as profit-making ventures, inevitably handle and settle all claims on the basis of economic considerations only. PMSLIC is prepared to settle meritorious claims as rapidly and equitably as possible, but also we have pledged to fight all claims without merit, even though the successful defense of an accused physician may prove more expensive than conceding negligence (where none exists) and making a total settlement.

Our board has taken this unique position with the hope that in time the company's commitment and resolution in this area will be obvious to the members of the plaintiffs' bar. This, in turn, should result in fewer claims being filed against PMSLIC physicians solely on the expectation that so-called "nuisance" claims routinely will trigger monetary offerings.

All claims against PMSLIC insureds are reviewed and evaluated by a panel of physicians before the company offers its legal response. No claim or suit may be settled without the consent of the insured physician. When the opinions of the insured and the company differ, the dispute is referred to a 12-man commission, set up by the Pennsylvania Medical Society for review and resolution. The commission's decision is binding on the insured and the company.

We monitor and report to our policyholders regularly on emerging specialty classification and rating territory statistics and reflect these into rate level adjustments as promptly as possible. Certainly one of the weaknesses of the commercial carriers previously active in the malpractice market was their statistical gathering capabilities which were programmed essentially for their respective "bottom lines" and for compliance with statutory requirements. They failed to tabulate their statistics in a manner which would be valuable to their insureds.

Finally, we are committed to keeping our leadership imaginative, flexible, and responsive to the needs and special interests of our more than 5,000 practicing physician policyholders.

**Conclusion**

The concept of the physician-owned and operated insurance company seems to have a promising future. Even the traditional insurance industry seems to share my cautious optimism. Rarely are we referred to any more as "bedpan mutuals," that derisive term worked to death by industry spokesmen just years ago.

One aspect of our potential success rests with physicians. We need their continued support especially with the burgeoning competition in many states, including Pennsylvania.

Collectively, physicians represent one of this country's smaller special interest groups. Most physicians are resigned to the fact that few others have the special interests of the doctor at heart.

Solidarity, a word of the trade union movement, appears to be the key to the long-term success of the physician-owned and operated insurance companies. The companies' long-term commitments to the medical fraternity must be reciprocated with the commitment of policyholder support by the individual physician. This support must not and cannot waver when competition from the outside promises equal coverage and equal concern for fewer dollars. It's a well-worn scenario and one which physicians should recognize and beware. Simply stated, for the physician-owned and operated insurance company, *solidarity spells survival!*

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

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Rebuttal

# Primary oat cell carcinoma of the larynx

**Gurijala N. Reddy, MD**
**Donald P. Vrabec, MD**
**Albert M. Bernath, MD**

In the June 1979 issue of PENNSYLVANIA MEDICINE, Drs. Stephen A. Lorenz, III, and Sebastian Arena reported a case of primary oat cell carcinoma of the larynx. As stated in the article, oat cell carcinoma of the larynx is a rare type of tumor. For this reason, what constitutes the optimum therapy for this tumor is controversial. We could find just ten other cases reported in the literature.

Drs. Lorenz and Arena reported on a 59-year-old black male with oat cell carcinoma of the larynx (left vocal cord with subglottic extension) and clinically negative neck nodes. Extensive metastatic work-up was negative.

The patient underwent total laryngectomy and left radical neck dissection. Out of 29 nodes in the specimen, two positive nodes for metastatic cancer were revealed. The follow-up and survival of this patient were not mentioned.

The authors concluded: "Optimum treatment should include wide field total laryngectomy with a classical radical neck dissection, and subtotal and paratracheal node dissection. Radiation therapy may or may not have a part in the treatment of this disease."

We feel this is a misleading and unwarranted statement. Chemotherapy plays a vital role in treating this disease and the authors fail even to mention this treatment. They also made no references to the most recent articles.[2-4]

Evidence in the literature supports the theory that oat cell carcinoma at the extrapulmonary site is of the same cell origin as that of the pulmonary type. Such tumors are malignant and aggressive. Surgery is contraindicated in almost all cases of oat cell carcinoma of the lung. This type of tumor, whether of pulmonary or extrapulmonary origin, is sensitive to radiation and chemotherapy.

As the literature indicates, controlling the tumor at the primary site (larynx) is not a major problem nor is it the determinant of survival.

Of the ten cases in the literature, seven patients were treated with surgery alone or in combination with radiation, either preoperatively or postoperatively or for recurrence. Despite what was thought to be adequate local therapy, six patients died of disseminated disease. One, with negative nodes, survived for two and one-half years. The remaining three patients, all with clinically positive neck nodes, were treated with combination chemotherapy, radiation therapy and surgery in one case. All three patients survived from twelve to fifteen months and were alive and clinically NED at the time they were reported.

One of the latter group is a patient from our institution, a 55-year-old white male with a large primary tumor in the larynx (involving aryepiglottic fold, extending subglottically with fixed cords) and bilateral neck nodes. Tracheostomy had to be performed for airway obstruction.

Biopsy revealed oat cell carcinoma. Metastatic work-up was negative. The patient was treated initially with chemotherapy (Cytoxan, Vincristine, Methotrexate and CCNU). He had improvement, and two weeks after therapy, tracheostomy tube was removed.

At six weeks, there was no evidence of tumor either in the neck or in the larynx. He received 4,000 rads in four weeks to the entire neck and 2,400 rads in eight treatments to the whole brain prophylactically according to the institutional protocol (further details reported in the case report). He is alive without evidence of disease at 22 months and has been off therapy for six months.

Since the dissemination of the disease is the major problem, these patients should be treated aggressively with systemic chemotherapy and local radiation therapy. Radical surgery has little role to play in the management of this disease. Laryngectomy will deprive the patients of voice. This is not justifiable if they can be treated successfully with modalities that preserve the voice. □

*The authors are associates in various departments at Geisinger Medical Center: Dr. Reddy, radiation; Dr. Vrabec, otolaryngology; and Dr. Bernath, medical oncology.*

## REFERENCES

1. **Bartels, L., Vrabec, D., Reddy, G., Bernath, A.:** Small cell anaplastic carcinoma of the larynx: Review of literature and report of a case. (submitted for publication).
2. **Bitran, J., Toledo-Pereyra, H.:** Oat cell carcinoma of the larynx. *Cancer 42:*85-87, 1978.
3. **Bone, R., Deer, D.:** Oat cell carcinoma of the larynx. *The Laryngoscope 88:*1190-1195, 1978.
4. **Mullim, J., Newman, R., Cultman, C.:** Primary oat cell carcinoma of the larynx. *Cancer 43:*711-717, 1979.

**DESCRIPTION:** Methyltestosterone is 17$\beta$-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Case report

# Gastrointestinal spasm from low dosage pilocarpine

Ralph S. Sando, MD

Gastrointestinal spasm secondary to the use of topical pilocarpine therapy should be known to ophthalmologists, internists, and abdominal surgeons. All physicians who deal with differential diagnoses of gastrointestinal disturbances should be aware of this complication from such a commonly used medication.

## Case report

A 52-year-old white female was referred for glaucoma consultation after finding elevated intraocular pressure on routine ocular examination. The patient's referring ophthalmologist had prescribed a trial of pilocarpine and acetazolamide therapy. She was using pilocarpine 1 percent twice daily in each eye when we saw her.

The ophthalmic and general medical history was non-contributory except for mild systemic hypertension treated with hydroflumethiazide and reserpine. Visual acuity was 6/12 in the right eye and 6/9 in the left. The intraocular pressure was 22 mm Hg in the right eye and 19 in the left, applanation.

The anterior chamber angles were wide open and normal. The optic discs had moderate-sized cups (0.4 cup/disc ratio) and were symmetric without definite pallor. The rims appeared healthy. Visual fields were apparently normal.

We supposed that the patient had elevated intraocular pressure with possible early disc changes but without definitive signs of glaucomatous disease. Mild therapy for the intraocular pressure seemed warranted.

The patient was instructed to stop using pilocarpine and to start epinephrine borate ½ percent topically once daily in the right eye. She developed bothersome palpitations, severe enough to wake her from sleep. Consequently, the epinephrine was discontinued.

Re-examination of the optic discs suggested a slight increase in the size of the optic cups. Minimal pallor of the neuroretinal rim developed but no detectable visual field loss developed. The intraocular pressure on no topical therapy for six weeks was 22 mm Hg in the right eye and 20 in the left. We advised a therapeutic trial of pilocarpine 1 percent once daily in the right eye.

Shortly after starting pilocarpine, the patient developed crampy pains in the right lower quadrant; frequently these were associated with nausea. The patient consulted her internist who prescribed prochlorperazine maleate and isopropamide iodide as needed. The symptoms continued to occur one to two hours after dropping pilocarpine in the right eye.

The patient returned to her internist who found no apparent etiology despite careful evaluations over several office visits. Diagnostic studies included a barium enema and intravenous pyelography. All studies proved negative.

Pilocarpine was continued during this time because it seemed to lower the intraocular pressure approximately 4 to 5 mm Hg in the treated right eye. When the patient returned for a follow-up visit six months later, she informed us that she had stopped using pilocarpine three weeks prior to her visit. She had discovered that discontinuing the pilocarpine relieved her abdominal discomfort. Four times she tested her hypothesis by resuming the pilocarpine, only to note that each time crampy, right lower quadrant pain inevitably ensued.

We directed a retest of her hypothesis. We found that using pilocarpine 1 percent once daily in the right eye was followed by bothersome abdominal discomfort approximately two hours after instillation of the drop. The symptomatology lasted from two to four hours. We asked the patient to participate in a brief controlled experiment using a placebo, but she declined because the abdominal distress was so unpleasant.

We advised stopping all therapy. Intraocular pressure measured 27 mm Hg in the right eye and 22 in the left. The visual field examinations continued to be normal. We elected to follow the patient on no therapy, realizing that other glaucoma medication probably would be needed in the future.

## Discussion

The ocular side effects of pilocarpine are documented well; frequently, they are bothersome, especially in the individual under 40 years old. Spasm of the ciliary body sphincter induces variable myopia, more symptomatic in the young and the myopic.[1] Other effects such as lid twitching, follicular conjunctivitis, conjunctival congestion, and periorbital pain recently have been reviewed.[2]

Although systemic side effects following the use of topical pilocarpine are documented, they occur less frequently.[3] When systemic side effects do occur, they are usually cholinergic in nature—nausea, vomiting, diarrhea, bradycardia, salivation, lacrimation, and sweating. Unpleasant dreams, depression, and delusions also occur.

## Conclusion

This case report documents gastrointestinal spasm associated with using small doses of topical pilocarpine. No similar cases were found of such hypersensitivity of the bowel to the cholinergic properties of pilocarpine used topically in such a low dosage.

Early recognition of this side effect would have spared the patient discomfort, expense, and the hazard of diagnostic procedures. □

*Dr. Sando is from the Glaucoma Service, Wills Eye Hospital, Philadelphia.* *The report was prepared with support from a Heed Foundation Fellowship and Glaucoma Service Fellowship 1977-78. Acknowledgement is made to George L. Spaeth, MD, for providing records and editorial assistance.*

### REFERENCES

1. **Aust, W., and Morlang, J.L.:** Pilocarpinmyopic. *Klin Monats Augenheilk 156:*30-39, 1970.
2. **Ellis, P.P.:** Pilocarpine therapy. *Survey Ophthalmol 16:*165, 1971.
3. **Epstein, E., and Kaufman, I.:** Systemic pilocarpine toxicity from overdosage. *Am J Ophthalmol 59:*109, 1965.

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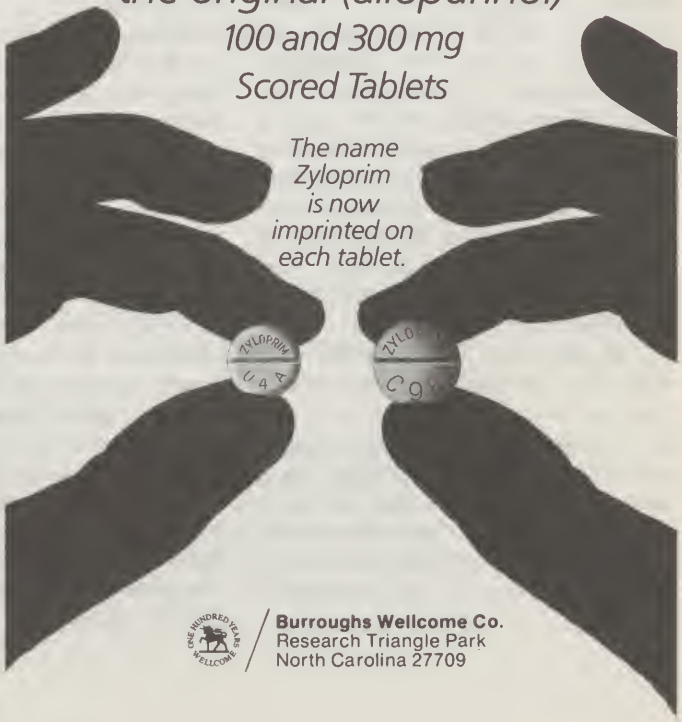


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# PSRO mandate includes records review, corrective action

**James F. Crispen, MD**

In March 1979, acting upon instruction of the Area IX PSRO Board, our staff notified delegated hospitals that routine monitoring would include a review of incomplete medical records. The response of some physicians and hospital administrative personnel was somewhat less than enthusiastic. A few questioned the authority of the PSRO to make the request. A few refused.

The incident troubled me because it displayed a general lack of knowledge of the medicare law and, more specifically, a lack of understanding of the PSRO program's intent. The purpose of such monitoring activities is to assure that meaningful history and physical examinations, admission notes, and progress notes are present.

The fact that these are basic requirements of the Joint Commission on Accreditation of Hospitals and individual hospital bylaws is pertinent. Such documentation represents criteria which are used in evaluating the **quality** of care rendered. Quality of medical care, as measured against that provided by a physician's peers, indeed, is an important and mandated PSRO function.

Adequate medical record documentation is essential. A review coordinator must screen the medical record to determine whether PSRO-approved criteria for admission and continued stay are met. When such documentation is inadequate or absent, federal patient benefits may be terminated by the physician advisor in accordance with PSRO procedures. Lack of appropriate documentation leads to questioning the appropriate utilization of medical services. Preventing overutilization of services is an important PSRO function.

The questions as to whether the PSRO has the right to peruse hospital records of federal patients and whether the confidentiality of the doctor/patient relationship precludes such action have been raised. Medicare and Medical Assistance programs are medical insurance plans. As such, they, like private insurance companies, must obtain an authorization for access to medical information. The contract signed by the beneficiary or recipient requesting coverage contains a clause permitting this access.

When specific payment is requested for an inpatient medicare stay, the patient must sign another authorization. For example, the following appears on the medicare inpatient billing form, Item 15:

> Patient's Certification, Authorization to Release Information and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

There is no breach of confidentiality because the patient permits access to his records.

Requests for reimbursement involving hospital medical care frequently have been the bases for fraud allegations. If payment is requested and made for services rendered on a daily basis in the hospital, daily visits must actually have been made, and **documentation** in the medical record substantiating the visits must be present.

When such cases are being investigated for fraud, the absence of documentation by the physician in the progress notes raises presumption that the patient was not seen on that particular day. In the absence of any proof of a visit, the presumption that no visit was made may be difficult to argue. A physician is entitled payment only for visits actually provided. If a colleague has substituted in caring for the beneficiary, that physician only should submit a bill. In teaching institutions where the process is more liberal, the attending physician should write and sign an admission note, a progress note at three-day intervals, and a final note. All other notes made by the resident should state that he and the attending physician have seen the patient on a particular day.

Under the 1977 amendments to the Social Security Act, the determination as to whether the services or items are substantially in excess of the beneficiary's needs or of a quality that does not meet professionally recognized standards of health care will be made on the basis of reports. These include sanction reports from the following sources:

- the PSRO for the area of service;
- state or local licensing or certification authorities;
- peer review committees of fiscal agents or contractors;
- state or local professional societies; or
- other sources deemed appropriate by HCFA.

The PSRO, when used, will be conclusive as to quality and necessity of services rendered. Physicians should be aware that effective October 25, 1977, the penalty for medicare fraud is a fine not to exceed $25,000 and a term of imprisonment not to exceed five years or both and that the crime constitutes a felony. Under the rules, when a conviction is found, suspension from the medicare and the medicaid programs is automatic.

The state or local licensing or certification agency is requested to investigate, to invoke available sanctions, and to inform HEW of its actions. Notice of suspension also is given to the general public and to beneficiaries treated by the practitioner.

During the period of suspension, the practitioner will not be paid on assignment from a beneficiary, and the beneficiary will not be reimbursed for services rendered by the suspended practitioner. Physicians suspended from the medicare program usually are asked to appear before a commit-

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*Dr. Crispen is medical director of South-central Pennsylvania Area IX PSRO. He is an associate in the hematology department at Polyclinic Medical Center, Harrisburg, and director of its blood bank.* *This article is reprinted from* Area IX PSRO Newsletter, *V. 2, No. 3.*

tee of the local medical society as well as the state medical society, the AMA, and the appropriate staff committee of the hospital in which they practice.

Although difficult to believe, Area IX PSRO representatives have reviewed discharged patients' charts which have included no history and physical, no admission note, and no progress notes. Although present, some progress notes are of no value with regard to their intended function: *i.e.,* a means of communication, between health care providers and the attending physician, which provides information useful in recalling the patient's condition at a future time.

The following progress notes serve as such an example:

6/24 — Patient watching TV.
6/25 — TV broken.
6/26 — TV repaired.
6/27 — Patient watching TV.

The individual reviewing such a chart would assume that the physician is more concerned about the technical well-being of the television than about the physical and emotional well-being of the patient.

Worthless progress notes of a substandard quality are not humorous. Such a physician is practicing medicine of a quality less than that of his peers and therefore, is abusing the medicare system. Further study of the medical record under consideration revealed that the notations unquestionably were entered retroactively. Obviously, if the physician had rendered no services on the days for which progress notes appear in a retroactive fashion or if he had billed the medicare program for services not rendered, he is guilty of fraud.

Figures which have been published indicate that the PSRO system is functioning and that the rise in the cost of medical care can be kept within reasonable limits without adversely affecting the quality of care. Should the PSRO effort fail, however, there is no doubt that mandatory controls will be legislated.

Physicians are the central element between the beneficiary and the provider hospital. They can do more than they realize to monitor the system and control its economic well-being. Only when physicians work together can these ends be accomplished. The physician is, and should continue to be, the key to the problem of cost containment.

Physicians must make a concerted effort to educate physicians in the functionings of medicare, the philosophic approach to medical care in a national health insurance program, the source of income in the trust funds, and the fact that the resources are finite. Given all the information, physicians should do what they can to aid the program. To do otherwise may result in its destruction — to the physicians' detriment. Overutilization is the most common abuse; fraudulent acts make up only a small percentage of the abuses perpetrated.

The philosophy of the Area IX PSRO has been to affect physicians' practices via a variety of educational methods. Unfortunately, in instances where repeated attempts at education and counseling fail, more forceful actions must be taken. Not to do so would be an abandonment of the PSRO's mandate.


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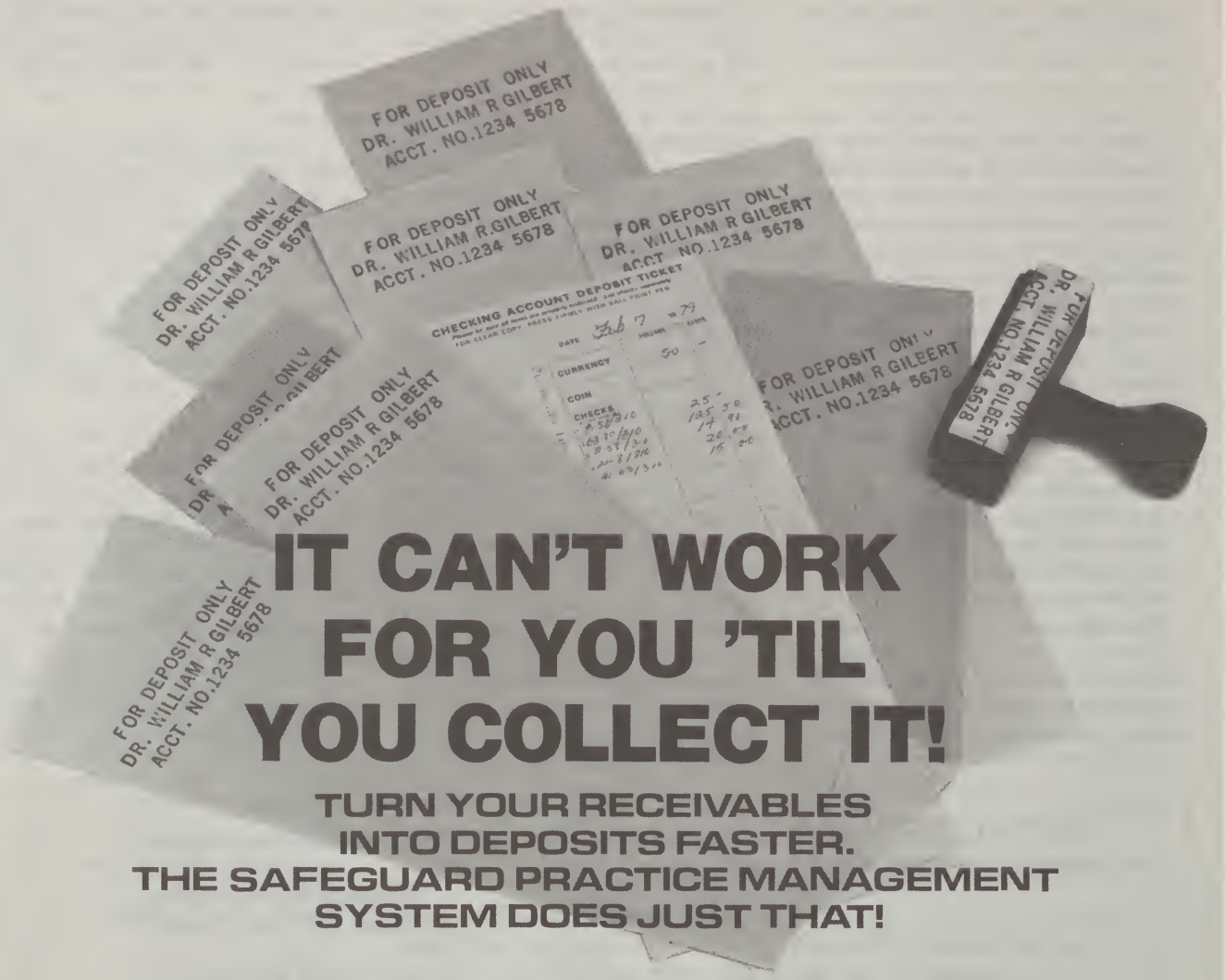


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# editorial

## Cost and quality of care — no guarantees exist

In an editorial in October 1978, we urged HEW to study results of pilot programs on second surgical opinions both in terms of cost savings and value to the patient. We recommended that the study be conducted before HEW instituted national programs.

At that time, two years of a three-year project had been completed by New York Blue Cross/Blue Shield. HEW reported results of this project as showing a 31 percent non-confirmation rate by consultants who rendered second opinions (*American Medical News,* January 11, 1980). Nonetheless the national campaign has begun through radio, television, and brochure.

HEW Secretary Patricia Harris said of the second opinion campaign, "We believe our information campaign can improve the quality of health care and help reduce unnecessary surgery. We want people to be aware that they have a right to get all the facts about their particular medical problems." To its credit, HEW has opposed a mandatory second opinion program.

The objectives of second surgical opinion programs, whether government-sponsored or privately supported, appear to be four-fold. Reducing unnecessary surgery is one goal. By eliminating unnecessary surgery and the attendant hospitalizations, medical costs may be reduced. Theoretically, the second surgical opinion should improve the quality of medical care because it removes the financial barrier to specialty consultation, which otherwise might be prohibitive. Finally, these programs should result in better informed patients by providing two or more opinions on the need for surgery.

The results of a number of second surgical opinion programs are now published. Most of these programs were voluntary. The conclusions of the studies are interesting.

The Blue Cross/Blue Shield of New York study, begun in January 1976, reported after twenty months that only 2 percent of subscribers sought a second opinion. Twenty-seven percent of these were not confirmed for recommended surgery by the consultant. The highest non-confirmation rates were in orthopedic and urologic procedures.

To date, the New York program is the only one that has produced a cost analysis. The estimated saving is $250,000 ($600,000 saving on surgery not performed less the cost of the program, $350,000).

The Cornell Elective Surgery Second Opinion Program, conducted from February 1972 through January 1978, published its results in *Annals of Surgery* in September 1978. They also report that 27 percent of patients were not confirmed for surgery by a board certified consultant. Highest areas of non-confirmation were in orthopedics, gynecology, and urology respectively.

Two observations reported by this study were that the majority of patients decided against surgery based on the second opinion, and that there is a "sentinel effect." "Sentinel effect" is defined as a decline in surgery rates as the second opinion program becomes known.

An example of a mandatory second opinion program is the Prudential Insurance Company's second option. This provides for less benefit payment if the patient does not seek a second opinion or if operative treatment is pursued after a non-confirmatory second opinion.

C. Rollins Hanlon, MD, director of the American College of Surgeons, said of the second option, ". . . the insurance company would adopt the cheaper of the two alternatives, presumably because it is cheaper, irrespective of whether the second opinion is more reliable, equally so, or less reliable than the initial advice. Particularly pernicious is the provision for decreasing the payment if the patient refuses to seek a second opinion. What began as an insurance program ends as a means of dictating the conduct of patients and their physicians" (*Bulletin of the American College of Surgeons,* August 1978).

Concluded voluntary second opinion programs, even if minimally used, seem to indicate that there is unnecessary surgery. The American College of Surgeons encourages consultation as a desirable part of good surgical practice, yet whether second opinion programs will improve quality of care remains to be proven. A delay in treatment may serve to impair quality of care.

Second opinion has the opportunity and promise of improving patient care by improving patient education and decision making. If the program fails to meet all other goals, it appears that this is the argument that HEW will use to continue its effort. It is perhaps the most valid of the major points offered.

Whether the second opinion programs will save money is questionable. The funding needed to operate the program must be weighed against the savings that are realized from surgery not performed, but cost ought not to be the primary determining factor in success or failure of this experiment.

Concerning mandatory versus voluntary second surgical opinion programs, no mandatory program will work for the benefit of the patient. With the aim of teaching patients as much as possible about their conditions and becoming active in the decision making processes in the dispositions of their care, a voluntary program is essential for success. Mandatory programs which apply financial penalties for failure to comply are unacceptable.

Cost is not the determining factor in quality of care, although it may be that quality care can be rendered at a lesser cost.

David A. Smith, MD
Medical Editor

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# in my opinion

## Medical school puts youth in red

The relentless pressure from our inflationary economy has forced us to consider another sizeable increase in our tuition. Although the exact amount of this increase has not been established, I suspect it will amount to $1,000 or more, setting our new tuition level at about $8,700.

Few families can pay this amount in addition to their annual living expenses without borrowing funds. Our students now are accumulating debts that average about $25,000 with a range that may reach $50,000 for individuals with great financial needs.

Although these tuition charges are high, tuition bears only a portion of the costs incurred by the School in the education of each student. We estimate that our annual cost per student totals $25,000. The difference between the tuition charge and the basic cost is met by contributions to the School from the Commonwealth of Pennsylvania and the federal government, from an increasing amount each year from contributions made through the practice of medicine by our clinical faculty, from endowment income, and from miscellaneous sources such as alumni annual giving.

Evidence suggests that the high tuition charged by medical schools is discouraging young people who come from middle or lower income families. These potential candidates select careers other than medicine, thus favoring the entry into the profession of a larger number of individuals who have no financial constraints on their ability to pay. This discernable trend toward making medicine a profession available only to the rich is real.

Always Americans have worked to provide opportunity for their youth. Generally they have not forced young people to assume unreasonable debts in order to become eligible for future opportunity. Medicine is the exception. Congress feels that it should not support the education of individuals who will most likely become the high earners of our society.

Although, in the past, many of us have had to assume sizeable debts to pay for our medical education, never before has the magnitude of indebtedness been so great. We do not know yet what will be the effect of this high level of debt upon the behavior of our students when they select their careers or when they practice within those careers.

A student who borrows $50,000 under the Health Education Assistance Loan Program must pay a total of $146,000 by the end of the repayment period. It is speculated that students necessarily will select specialties in which they can earn more so that they will be able to manage their debt burden more easily. One can predict with confidence that the debt payments ultimately will be charged to patients as a part of the future professional fee.

The present policy which forces medical students into such great debt strikes me as shortsighted and against the American tradition. It sets up this self-fulfilling prophecy: medical students will become physicians who aspire to high incomes.

Medical education dissociated from financial intrusions offers the best hope for developing professionals oriented toward the highest professional ideals. In my total experience in medical education I have never heard medical students talk so much about financing as they do now.

What can physicians do? It seems to me that each of us who received a medical education and established a successful professional career ought to decide whether we have an obligation to the current medical students. One way for us to protect our current classes is, for those of us who can afford it, to pay back to the schools a fraction of our income as a dividend on the advantage we received through our education in a more favorable time. Individuals who are earning an average physician's net income ought to consider annual contributions that range between $1,000 and $5,000.

Physicians should become knowledgeable about the general problems of financing our nation's private medical schools. Once informed, then you can discuss your beliefs with your senators and local congressmen. We all must educate our legislators about the problems of young medical students. We must do all that we can to educate the general public.

Work through your county and state societies and make known your beliefs to the AMA. The societies of organized medicine seem to have more effective lobbying efforts than the societies of medical education.

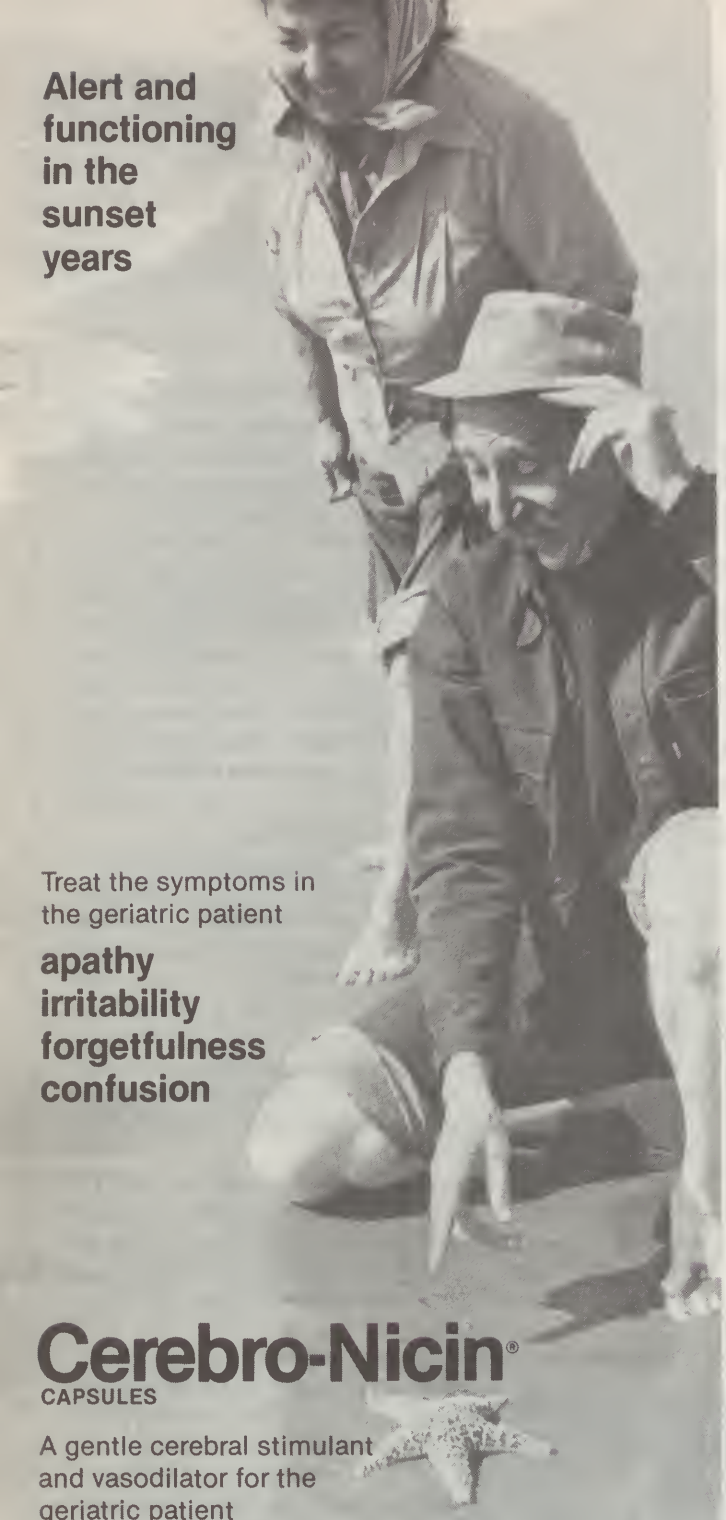
We in medicine are bound together through ties that are remarkably different from any other profession. Some call us a club; some, the medical fraternity. We know that we have all been given a privileged opportunity to serve our fellow man and have benefited financially from that undertaking.

Presently our profession is misunderstood. The public does not believe so strongly as it once did that most of us set the quality of our professional performance above all else. Instead, our present students perceive an attitude that likens them to developing businessmen, and, like businessmen, requires them to make personal financial investments in their future rewards. What a sad concept of our caring profession!

Edward J. Stemmler, MD, Dean
University of Pennsylvania
School of Medicine

## Looking for better way

I read with interest the article entitled "Blue Shield Payment Mechanism Explained" in the January issue. In my opinion, the "Prevailing Fee" system of Pennsylvania Blue Shield is one of the worst things physicians have ever




agreed to do from the standpoint of patient relations.

I have no argument with the amount of any fee nor the actual formula used. My argument is with the subtle mechanics of the system. In our inflationary economy, fees must be raised from time to time, and under the PBS profile system a physician cannot raise his fees without appearing to charge too much.

A new fee for a specific service must be charged more times during the previous calendar year than was the old fee. If not, then the profile will not be raised. What this means is that physicians must raise their fees early in the current calendar year in order to assure that the profile will increase the following July.

Therefore, for more than one year, the PBS payment notifications to a physicians' patients will show a fee that is higher than the "Prevailing Fee" allowance. This gives patients the impression that a physician is overcharging. If a profile system is not properly managed, a physician can be in this position for 24 months or longer. There is practically nothing a physician can do within this system to keep from looking bad. By the time a new fee is allowed, it is time to increase again.

Patients have no way to make comparisons, so they assume physicians charge too much because Blue Shield knows what the fee ought to be, and they won't allow it in full.

There should be a better way. One that will allow the conservative, concerned physician to raise his fees only when absolutely necessary, to do it within the confines of the system, and not still come out looking like a Machiavellian merchant to his patients. Pennsylvania physicians should get off their political rumps and do something about the things that unfairly are tarnishing their image.

Robert E. Fischer, Business Manager
Greenville Medical Center, Greenville

## To walk in another man's moccasins

*Reprinted from* Lackawanna Medicine, *Third Quarter, 1979.*

Several months ago my wife and I had reservations at a posh restaurant in our area. Our reservation was for 8:00 p.m. and we arrived with another couple at about 7:50 p.m. We were told at that time that our table wasn't quite ready and that we could wait in the bar until we were paged. Well, ten minutes led to thirty and that led to an hour, so around 9:30 p.m. we were finally paged and shown to our table.

By this time we were starved and completely annoyed. What had promised to be a pleasant, relaxing evening had turned into one of annoyance and frustration. Despite the excellent food and service, we all vowed never to return to this particular eatery. You see, the management had lied to us; we were assured a firm reservation, an appointment if you wish, for a particular time, and the contract had not been fulfilled.

Several years ago we were at the New Jersey shore with family and friends and heard of an excellent seafood restaurant. We knew in advance that its policy was first come first served. Despite this we were willing, yes even anxious, to stand in line for one hour and twenty minutes to test its cuisine. Although the wait was not a pleasant one, once

seated we had a thoroughly enjoyable evening without grumbling and without any feeling of being had.

Why the difference? I feel the basic difference is that in one case an implied contract was unilaterally and without explanation broken. In the other, the contract, despite its obvious shortcomings, was kept.

Perhaps in the one case management was insensitive to its patrons. In the second case, management knew what it could deliver, was sensitive to its patrons' willingness to accept some discomfort, and had communicated the essence of the service which it could deliver. The patrons were free to choose to accept or reject the conditions of the implied contract.

Just what is sensitivity? In the Bible, it is "Doing unto others as you would have them do unto you." Indian folklore may say "Being able to appreciate how it would be to walk in another man's moccasins." The dictionary defines sensitivity as "the attribute of one who has by nature a specially keen or delicate capacity for feeling or responding."

Now what this preamble has to do with medicine, medical care delivery, and doctors in particular may not be clear to many readers. If it is not obvious to you, then I suggest you take a close, introspective look at yourself and your every day modus operandi because you are sadly lacking in one of the most valuable and essential attributes of a physician, sensitivity.

Having the same complaint communicated to me time and time again by patients, friends, family, and even colleagues, I felt it was not only necessary but imperative to articulate the collective unhappiness, anger, discomfort, and disgust over having to spend countless man hours in the waiting rooms of physicians who supposedly work by appointment, or having to sit for hours before a physician will give the sick and worried an audience even after that physician had an implied contract *i.e.* an appointment to see said supplicant at a given point in time.

Medicine is, after all, a service profession and such service should be extended in a professional, dignified, and yes, timely manner. If because of the nature of your personality or your specialty you cannot operate on an appointment system, make that fact clear to your patients, then your patients can choose to accept or reject that condition for their ongoing relationship with you. But if you freely and willingly choose to run your professional life by a time schedule it is incumbent on you to live by the rules you have set, except under the most extraordinary circumstances, which then must be explained carefully to your patients.

If this article succeeds in sensitizing physicians to the feelings and expectations of their patients, then it is worthwhile. If it accomplishes its purpose which is for all of us to take a fresh look at the way we and our offices interact with our patients, then it is worthwhile.

If, on the other hand, it makes us defensive and hardens our hearts and makes us more insensitive and arrogant, then God help us and our profession, for our patients and society certainly will not.

Joseph N. Demko, MD
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# Corporations must keep current minutes, agreements on file

Leif C. Beck, LL.B., CPBC Vasilios J. Kalogredis, JD, CPBC Geoffrey T. Anders, CPA, JD

In our capacities as consultants and attorneys for physicians, we have come in contact with many professional corporations whose minute books are either nonexistent or obsolete. Some were last updated years ago, often as far back as the corporation's inception.

Particularly, we are alarmed by the lack of up-to-date employment agreements between professional corporations and their physician-employees. To some such documents may seem insignificant details; in reality they are essential.

**Importance**

We are amazed at the number of physicians who do not have up-to-date written employment agreements with their professional corporations. This category often includes groups who had labored to attain a workable partnership agreement prior to incorporating.

When a group incorporates the terms and understandings set forth in the partnership agreement can and should be documented in the corporate employment and stock purchase agreements. The substance need not change, even though the form must change to reflect the new positions of the physicians as employees and shareholders of a corporation.

Employment agreements often are sought during IRS audits. When they are not available or do not portray the actual conditions from a tax standpoint, otherwise avoidable problems can ensue.

In conjunction with stock purchase agreements, employment agreements provide practical protection in group practice settings as to the rights and obligations among physicians. Without written documents, unnecessary misunderstandings can occur.

*The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.*

It is imperative that an employment agreement be individualized to each physician's needs and understandings. Canned documents will not suffice.

Documents must portray the changing realities in the corporation. This demands updating them. It need not involve large legal costs or a total redrafting of the employment agreement. A short addendum usually can document the specific item being changed. These measures can be accomplished easily and can protect against the potentially severe tax, legal, and practical consequences of obsolete documents.

Having an obsolete or inaccurate employment agreement can be disastrous as numerous audits have shown. The *Horowitz* case[1] is an example. The taxpayer, the majority shareholder and president of the corporation, received compensation and reimbursement of expenses at the discretion of the corporation's board. He was never paid the full compensation provided in the agreement. The corporation reimbursed him for some expenses for which it was not legally responsible per the employment agreement. This loose handling of details forced the tax court finding against the taxpayer.

We encourage physicians to have written employment agreements that comply with their desires and proper corporate and tax law. We also advise that physicians handle things in a manner consistent with the documents.

**Hedge clauses**

Many incorporated physicians' employment agreements include a form of hedge clause, sometimes called an Oswold resolution.

Basically the clause provides that should the IRS determine any part of the physician's compensation, fringe benefits, or expense arrangements nondeductible, either as "unreasonable compensation" or as personal expenditures, the physician would repay such amounts to his corporation. This approach supposed that the physician's repayment would be deductible on his personal tax return, thereby discouraging IRS attack.

We continue to oppose such clauses. Recent Tax Court decisions and other rulings strengthen our belief. Several cases dealt with IRS assertions of unreasonable compensation, despite hedge clauses. The Tax Court repeatedly has held that the clauses not only do not prevent IRS attack, the hedge clause reimbursement provisions themselves help to prove the taxpayers' knowledge that some or all remuneration or expenses may be improper. The clauses worked against the taxpayers.

From a practical standpoint, many physicians would be unwilling or unable to repay the amounts to the corporation. Furthermore, some cases have held that the payments back to the corporation were nondeductible, making the taxpayer's position even worse. The repayments to the corporation thus are treated as income subject to tax. The corporation then must find a way to repay the physician. The hedge clause does not solve the problem; at best it restores the original tax planning problem.

IRS auditors are interested in the tax situation for the year being audited. The fact that the physician's repayment may be tax deductible to him in the year made is not important since it has no impact on the year under audit.

**Remuneration**

The employment agreement should specify the salary and incentive provisions for the physician. Once again, they must portray the realities and, if necessary, an addendum should be used. Salaries set unreasonably high or unduly low can cause problems.

Many physician's employment agreements presently provide for incentive compensation to help combat potential unreasonable compensation and wage control possibilities. One example of this follows:

> Recognizing that the employer's income above the anticipated level derives primarily from greater than anticipated productivity by the employee, the employer will pay additional incentive compensation of _____% of any gross income received during the year in excess of $_____.

No one can assure that such a clause will succeed against possible wage controls. Nonetheless, we believe it is worth the effort.

### Sick and termination pay

The employment agreement should specify sick and termination pay provisions. These can be particularly important in a group practice where vague provisions can cause problems.

Many employment agreements do not provide an Internal Revenue Code Section 101(b) $5,000 death benefit, sometimes called a widow's benefit. This is an income tax free benefit, available only upon termination of employment on account of death. It does not apply to amounts to which the employee possessed a nonforfeitable right of receipt while living.

### Business expenses

As we described above, an employment agreement should state clearly who should pay what expenses. The documents should reflect the realities.

Whether the corporation or the physician should pay the business expenses varies but from a tax and legal standpoint, there is little difference. Often the personal preference of the physician and his advisors decides the matter.

We must alert physicians to one potential problem. If a corporation pays some marginal business expenses and the IRS disallows them, the potential tax cost can be great. The IRS has been disallowing them at the corporate level and taxing them as preferential dividends at the physician-shareholder level.

For example, assume a $3,000 automobile deduction was disallowed. The corporate tax (assuming 20 percent levels) would be $600, ignoring state corporate taxes. The physician could be taxed as high as 70 percent, $2,100, plus state taxes. That totals at least $2,700. If the physician had taken the $3,000 as salary, he would have paid $1,500 in federal taxes.

This example is not intended to discourage corporate payment of business expenses but to present the other side of the issue and the potential damage that marginally deductible items can create if run through the corporation.

### Conclusion

Employment agreements are crucial. They must be individualized and they must portray the actualities of the corporation. The cost of having them is insignificant compared with the costs of not having them.

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1. *Leon D. Horowitz and Shirley Horowitz v. Commissioner*, CCH Dec. 35, 835(M); Dkt. 11806-77, January 17, 1979, T.C. Memo. 1979-27.


## Institute for Medical Education and Research

### Geisinger Medical Center

### Continuing Education Programs 1979-1980

**Hematology & Oncology in Office Practice**/Wednesday, April 2, 1980/1 p.m. to 5 p.m./$30

**Topics in Ophthalmology***/Saturday, April 12, 1980/9 a.m. to 1 p.m./$30

**Dermatologic Diagnosis & Therapy**/Wednesday, April 16, 1980/9 a.m. to 5 p.m./$45

**12th Annual Conference Devoted to Children***/Saturday, May 3, 1980/9 a.m. to 1 p.m.

**Common Problems in Immunology & Allergy**/Wednesday, May 7, 1980/9 a.m. to 5 p.m./$45

**Diabetes Meeting-Pocono Hershey**/Friday, Saturday & Sunday, May 30, 31, & June 1, 1980/9 a.m. to 1 p.m.

**Coronary Artery Disease**/Wednesday, June 4, 1980/9 a.m. to 5 p.m./$45

Annual Pocono Course*/August 13-17, 1980/9 a.m. to 1 p.m.

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As an organization accredited for continuing medical education, the Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. (Refer to each program — full day - 7 hours credit and ½ day - 4 hours credit).

**For further information write to/Millie K. Fleetwood, Ph.D./ Geisinger Medical Center/Danville, Pennsylvania 17821/or telephone 717/275/6925**

# classifieds

## PHYSICIANS WANTED

**General surgeon** — North Carolina. Needed for University owned hospital in small coastal town. This private practice opportunity is ideal for an experienced general surgeon who would enjoy a relaxed, productive life style in a desirable climate on the coast. Send CV to Department 839, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Ophthalmologist** — Retinal specialist to associate with busy general ophthalmologist in Philadelphia. This might be a part-time association. Please send curriculum vitae in reply to Department 838, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Emergency room physician** — Immediate opening for full time emergency room physician. Salary and fringe benefits are competitive. Send resume to Mr. Richard A. Anderson, Administrator, Canonsburg General Hospital, Barr Street, Canonsburg, PA 15317.

**Psychiatrists and physicians** — Board certified or Board eligible Pennsylvania Licensure required. Immediate openings. Excellent opportunity to work in developing new programs in a state hospital. Salary competitive. Limited housing available. Excellent fringe benefits. 40 miles east of Pittsburgh. Call (412) 459-8000 or write to Ray Bullard, MD, Superintendent, Torrance State Hospital, Torrance, PA 15779. An Equal Opportunity Employer.

**Private practices** — for general practitioners and internists sponsored by teaching hospital in Illinois. Paid interviews, guaranteed income. Relocation. Special arrangement for rent and equipment. No fees. Will assist with state license. Resume-Professional Referrals, 107-14 Queens Blvd., Forest Hills, NY 11375 or call 24 hours (212) 263-0400.

**Emergency medicine opportunities available** — Opportunities available to assume clinical and directorship responsibilities in several emergency departments located in western Pennsylvania. Excellent income, flexible scheduling, and paid professional liability insurance. Part-time opportunities also available. For details, send credentials in confidence to Mr. James Thomas, 230 Park Avenue, Suite 303, New York, New York 10017, or call collect (212) 599-0060.

**Family practitioner** — Tampa Bay Area, Florida. Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., Attn: Jerry Williamson, MD, 1417 South Belcher Road, Clearwater, Florida 33516; (813) 535-3474.

**Internist** — Tampa Bay Area, Florida. Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, MD, Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516; (813) 535-3474.

**Family practitioner needed** — Board eligible or certified, full-time position for a multispecialty primary care center. Located in Northeastern Pennsylvania, 20 minutes from Pocono Mountain resorts and within two hours of New York City and Philadelphia. Position available on or before July 1. Competitive salary and fringe benefits. Contact Alfonso Gomar, MD, Medical Director, 959 Wyoming Avenue, Scranton, PA 18509, (717) 344-9684. Scranton Primary Health Care Center is an Affirmative Action, Equal Opportunity Employer.

**Unique opportunity** — for practice of family medicine, pediatrics, or internal medicine in Southeastern Pennsylvania. Attractive new office space. Write Department 837, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Pediatrician wanted** — provide pediatric services at Silver Springs, Martin Luther school, a residential treatment facility for emotionally disturbed children. Requires approximately 4-5 hours every two weeks doing annual physicals, routine medical needs, and availability for phone consultations. Prefer affiliation with Chestnut Hill, Montgomery, or Sacred Heart Hospital. Contact Robert F. Bartelt, Silver Springs, Martin Luther School, Township Line Road, Plymouth Meeting, PA 19462.

**Ob-Gyn** — to join solo Ob-Gyn in central Pennsylvania community. Modern hospital with excellent staff. Send curriculum vitae to Department 839, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Physicians** — for clients in Pennsylvania, Massachusetts, and Ohio. Specialists in FP, PD, radiotherapy, ENT, psychiatry, physical medicine, and a director Ob-Gyn. Please call E. J. Mowry, (215) 348-8700.

**Pediatrician and other physicians wanted** — for Bethel Park, Pennsylvania, suburb of Pittsburgh, 35,000 people. New professional building. Call (412) 833-6188.

**Directorship and staff** — applications are now being accepted for full-time and part-time, Emergency Department and In-Hospital positions. Attractive opportunities are now available with reputable hospitals in economically sound areas of Ohio and peripheral states. Forward your C.V. and references to Doctors Services, Inc., Executive Commons East, Suite 313, 29525 Chagrin Blvd., Cleveland, Ohio 44122.

**Pediatrician wanted** — to join two pediatricians for existing vacancy in three man department. This is part of a multi-specialty group of primary care physicians located in Northwest Pennsylvania. This group has been established for 33 years and serves a patient population area of 75,000. There are new office facilities fully equipped and ready for occupancy. Full membership in the corporation will be offered after one year. A very moderate investment is required. We offer an excellent starting salary and a full range of fringe benefits. Contact Robert W. Monroe, MD, Greenville Medical Center, 90 Shenango Street, Greenville, PA 16125, telephone (412) 588-4240.

**Camp Doctors Needed** — Camp Chen-A-Wanda, fine Pennsylvania Co-ed camp. Season begins June 29, ends August 23. Physicians accepted for two weeks to entire season. Excellent living accommodations for doctor and family. Write: Mr. and Mrs. Morey Baldwin, 8 Claverton Court, Dix Hills, NY 11747. Call Collect (516) 643-5878 (evenings).

**Career opportunities** — Throughout Pennsylvania and from coast-to-coast for physicians in all specialties. All Fees assumed by employers. Send CV with objectives to Medical Recruitment Division, Dr. Personnel of Pittsburgh, Inc., (31 offices nationwide), 121 University Place, Pittsburgh, PA 15213, (412) 621-9975.

**Psychiatrist** — board-certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact George E. Gittens, MD, Acting Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411, (717) 586-2011.

**Surgical first assistant** — Excellent opportunity for a Pennsylvania licensed physician to serve in a responsible position in a progressive suburban Philadelphia, 305 bed acute care, JCAH accredited hospital. Prefer Board Certification or eligibility in General Surgery or Ob/Gyn. Some evening and night on-call coverage required. $45,000 per year plus vacation, sick leave, hospitalization, malpractice insurance, and disability insurance. For further information contact Richard L. Martin, Administrator, Delaware County Memorial Hospital, Drexel Hill, PA 19026; telephone (215) 259-3800.

**NEEMA Emergency Medical** — a professional association — Emergency medicine positions available with emergency physician groups throughout Pennsylvania, New York, New Jersey, Michigan, and Southeastern U.S., including all suburban, rural, and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to NEEMA Emergency Medical, Suite 400, 399 Market St., Philadelphia, PA 19106. In PA call (215) 925-3511, those outside of PA call 1-800-523-0776.

**House Staff Physician** — Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $40,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Executive Director, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

**GP/Internist**—needed for 600-bed ECF and ambulatory multidisciplinary Health Care Facility, serving a population of 100,000. No administrative responsibility, overhead, or financial risk. Provides insurance, vacation, sick leave, and continuing education. $40,000+, negotiable pending experience and qualifications. Contact Yorktowne Health Services, Inc., P.O. Box 3547, York, PA 17402.

**Anesthesiologist** — Associate, licensed in Pennsylvania. Board eligible or certified. 212-bed general hospital in western Pennsylvania. Extremely active surgical service. Competitive compensation plus comprehensive benefit program, including liability insurance, educational leave, etc. Mail resume to Mr. Robert L. Engel, Administrator, Armstrong County Memorial Hospital, Kittanning, PA 16201.

**Post Residency Fellowship** — in geriatric psychiatry for psychiatrists or primary care physicians. NIMH sponsored training program emphasizes interdisciplinary, comprehensive care of ambulatory patients, geriatric medicine and social gerontology as well as geriatric psychiatry. Opportunities in inpatient and outpatient care, community liaison and research. Contact Monica D. Blumenthal, MD, PhD, Geriatric Psychiatry Program, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15261.

**Physicians** — Excellent opportunities exist throughout the nation. Hospitals, clinics, solo practices, etc., in a broad range of specializations. Send us your curriculum vitae and we will compare your objectives with our assignments. We can confidentially and successfully complete your search. Doctors Services, Inc., 29525 Chagrin Blvd., Suite #313, Cleveland, OH 44122.

**Emergency Room Physician** — Six year old, 212 bed community hospital, Western Pennsylvania. Full-time position available. Physician participates in all hospital benefit programs including liability insurance. In addition to 3 weeks paid vacation, an additional 5 days is made available for continuing education in Emergency Medicine each year. Write or call: F.O. Robertson, MD, Director, Emergency Medical Services, Armstrong County Memorial Hospital, Kittanning, PA 16201. (412) 543-8404 Collect.

**Orthopedic Surgeon Wanted**—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Medical director** — Allied Services, located at the foothills of the scenic Pocono Mountains, is the largest comprehensive-care rehabilitation facility in the eastern United States. Allied is currently seeking a board certified physiatrist for the position of medical director, who will be responsible for the overall medical services of the accredited 90-bed Institute of Rehabilitation Medicine, and supervise a full-time physiatry staff. The position offers tremendous opportunity, salary, and fringe benefits. For more information, call collect (717) 348-1343, Michael J. Aronica, MD, Allied Services, 475 Morgan Highway, Scranton, PA 18508.

**Staff Psychiatrists** — Full or Part Time positions immediately available. Our hospital is looking for psychiatrists with fresh ideas and strong convictions on public sector mental health care. We are located in pleasant, residential Northeast Philadelphia and can offer the area's unparalleled opportunities for professional growth and development. Good salary and benefits. Requirements are PA State license and board certification or eligibility. Contact, in strict confidence: Franklyn R. Clarke, M.D., 14000 Roosevelt Blvd., Phila., PA 19114, (215) 671-4101.

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**Physician** — to join a three man corporate family practice to replace a member that is leaving. Suburban area and many benefits. Contact: L.B. Shaffer, MD, 1000 Welsh Road, Ambler, PA 19002.

**Resident physician** — and resident nurse wanted for well-established children's sleepaway camp, Wayne County, Pennsylvania. Two and four weeks available in July. 2 RNs on duty. Families accommodated and are welcome to participate in all activities. Call (516) 466-8698 collect evenings.

**Pennsylvania Emergency Physician** — 200-bed general hospital located in western Pennsylvania university community. New modern Emergency Department. Salary highly competitive. PA license required. Contact: William B. Yeagley, MD, Director of Department of Emergency Services, Indiana Hospital, Indiana, PA 15701.

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**Radiologist**—Board Certified in radiology and nuclear medicine, currently associated with a teaching hospital, desires relocation in Eastern Pennsylvania. Part-time position considered. Write Department 836, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

## CONTINUING EDUCATION

**1980 Southeast Emergency Medicine Congress** — DeSoto Hilton Hotel, Savannah, Georgia, May 7-9, 1980. Sponsored by 10 Southeast chapters of American College of Emergency Physicians and Region IV of Emergency Department Nurses Association. Fees: Physicians $220, $190 for ACEP member; Nurses $110, $75 for EDNA members. Contact: R.T. Lowry, MD, 901-D Kildaire Farm Road, Cary, North Carolina 27511. (919) 469-1942.

**Sixth Annual Family Medicine Review Course** — June 1-6, 1980 Annapolis, Maryland. Sponsored by the University of Maryland School of Medicine. Information contact: Program of Continuing Education, 10 S. Pine Street, Baltimore, Maryland 21201 or (301) 528-3956.

### FOR RENT

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### MISCELLANEOUS

**Financial Planning-Tax Havens** — Reduce personal tax liability. Increase net worth. Improve profitability of your private, group, or corporate practice. Reduce, defer, or eliminate Federal/State taxes—legally. U.S. Tax Planning Corporation conducts seminars for doctors nationally (see advertisement this issue). For information, call toll-free 1-800-543-3000-operator, 220 anytime.

**Physician's assistants** — Become a warrant officer in the Pennsylvania Army National Guard in a unit near your home. Serve one weekend a month and a fifteen (15) day annual training period each year. You will be eligible for continuing professional education, monthly pay, and a substantial non-contributory retirement plan. Enjoy the personal satisfaction of doing an important job for your state and nation. For further information contact Major Eugene P. Klynoot, Department of Military Affairs, Pennsylvania Army National Guard, Annville, PA 17003. Telephone (717) 783-3430.

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**Department of Rehabilitation Medicine**
**Thomas Jefferson University Hospital**
**11th and Walnut Streets**
**Philadelphia, PA 19107**
**Telephone: (215) 928-6573**

# obituaries

*• Indicates membership in the Pennsylvania Society at time of death*

• **Charles C. Alfano,** Media; Hahnemann Medical College, 1934; age 72, died February 13, 1980. Dr. Alfano was a proctologist at St. Agnes Medical Center for 25 years.

• **Bernard H. Berman,** Washington; University of Cincinnati School of Medicine; age 64, died January 14, 1980. Dr. Berman was a cardiologist. He founded the Southwestern Pennsylvania Heart Association and served on the faculty of the University of Pittsburgh School of Medicine.

• **John Lott Boyer,** Biglerville; Jefferson Medical College, 1930; age 78, died January 8, 1980. Dr. Boyer served as head of radiology at Warner and Hanover General hospitals. On December 17, 1979, he received the PMS Recognition Award for 50 years of service to the medical profession.

• **Joseph J. Buch,** Charleroi; Georgetown University School of Medicine, 1937; age 66, died December 12, 1979. Dr. Buch had been on the staff of Mon Valley Hospital.

• **Arnold Van Osdal Davis,** West Reading; Duke University School of Medicine, 1954; age 51, died January 31, 1980. Dr. Davis, a general and vascular surgeon, was an assistant clinical professor of surgery at the University of Pennsylvania. He was on the staffs of the three hospitals in the Reading area.

• **Wilson Dougherty,** Pittsburgh; University of Pittsburgh School of Medicine, 1938; age 67, died February 9, 1980.

• **Robert John Hunter,** Philadelphia; Medico-Chirurgical College of Philadelphia, 1904; age 97, died January 31, 1980. Dr. Hunter, an otolaryngologist, was the first Army flight surgeon to report for duty at the start of World War I. He was on the staff at Philadelphia General Hospital and ran the hearing center of the Hospital of the University of Pennsylvania for many years. He founded and acted as curator of Philadelphia General's Osler Memorial and Blockley Historical Museum where he amassed medical records from the Colonial period.

• **Thomas Charles Jacob,** Springfield; Jefferson Medical College, 1954; age 53, died December 29, 1979. Dr. Jacob was a radiologist practicing in Havertown.

• **Roosevelt Ralph Juele,** West Deptford, New Jersey; Hahnemann Medical College, 1933; age 72, died January 27, 1980. Dr. Juele was a former chief of surgery at St. Agnes Medical Center.

• **Paul S. Schantz,** Ephrata; Hahnemann Medical College, 1934; age 70, died February 5, 1980. Dr. Schantz had practiced for 45 years in Ephrata. He was past president of the Central Pennsylvania Homeopathic Medical Society and the Homeopathic Medical Society of Pennsylvania; past treasurer of 25 years standing of the American Institute of Homeopathy; and a 10-year executive secretary of the Pan-American Homeopathic Medical Congress.

• **William C. Schultz, Jr.,** St. Petersburg, Florida; age 79, died October 31, 1979. Dr. Schultz had been a member of the Franklin County Medical Society.

• **Frank E. Wolcoff,** Philadelphia; Temple University School of Medicine, 1928; age 74, died January 7, 1980. Dr. Wolcoff was a staff member at Roxborough Memorial and Germantown hospitals. He was chairman of the intern committee at Roxborough Memorial hospital and taught at the Medical College of Pennsylvania.

• **James E. Woodhouse,** Bradford; University of Toronto Faculty of Medicine, Toronto, Canada, 1935; age 73, died January 11, 1980.


## Special Care for Children - A Symposium

**June 4 & 5, 1980**

The Hershey Motor Lodge & Convention Center
Hershey, Pennsylvania

**Guest Speakers:**

**John Chappell, MB, BCh, FRCS**
Professor of Pediatric Surgery
Johannesburg Hospital
University of the Witwatersrand
Johannesburg, South Africa

Professor Chappell is an internationally known pediatric surgeon whose children's hospital is one of the largest in the world.

**Howard Eigen, MD, FAAP**
Assistant Professor of Pediatrics
Director, Pediatric Pulmonology Division
James Whitcomb Riley Hospital for Children
Indiana University School of Medicine

Dr. Eigen established the Division of Pediatric Pulmonology at Riley Hospital and is well known for his work on cystic fibrosis and asthma.

The symposium presentations will emphasize the impact of neonatology, trauma, and specific organ failure on the general care of children.

**For further information contact Continuing Education, Department 4004, The Milton S. Hershey Medical Center of The Pennsylvania State University, Hershey, PA 17033 (717) 534-8898.**

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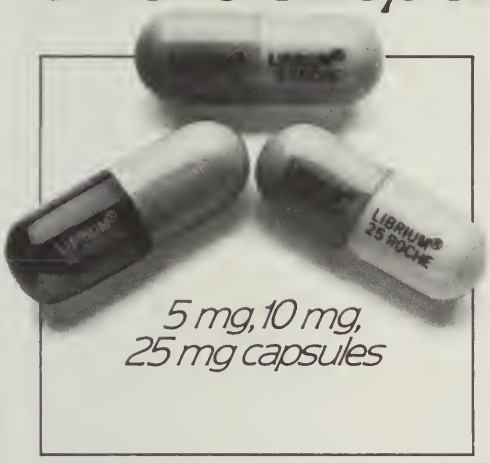


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**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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# Pennsylvania Medicine

Vol. 83, No. 5 MAY 1980

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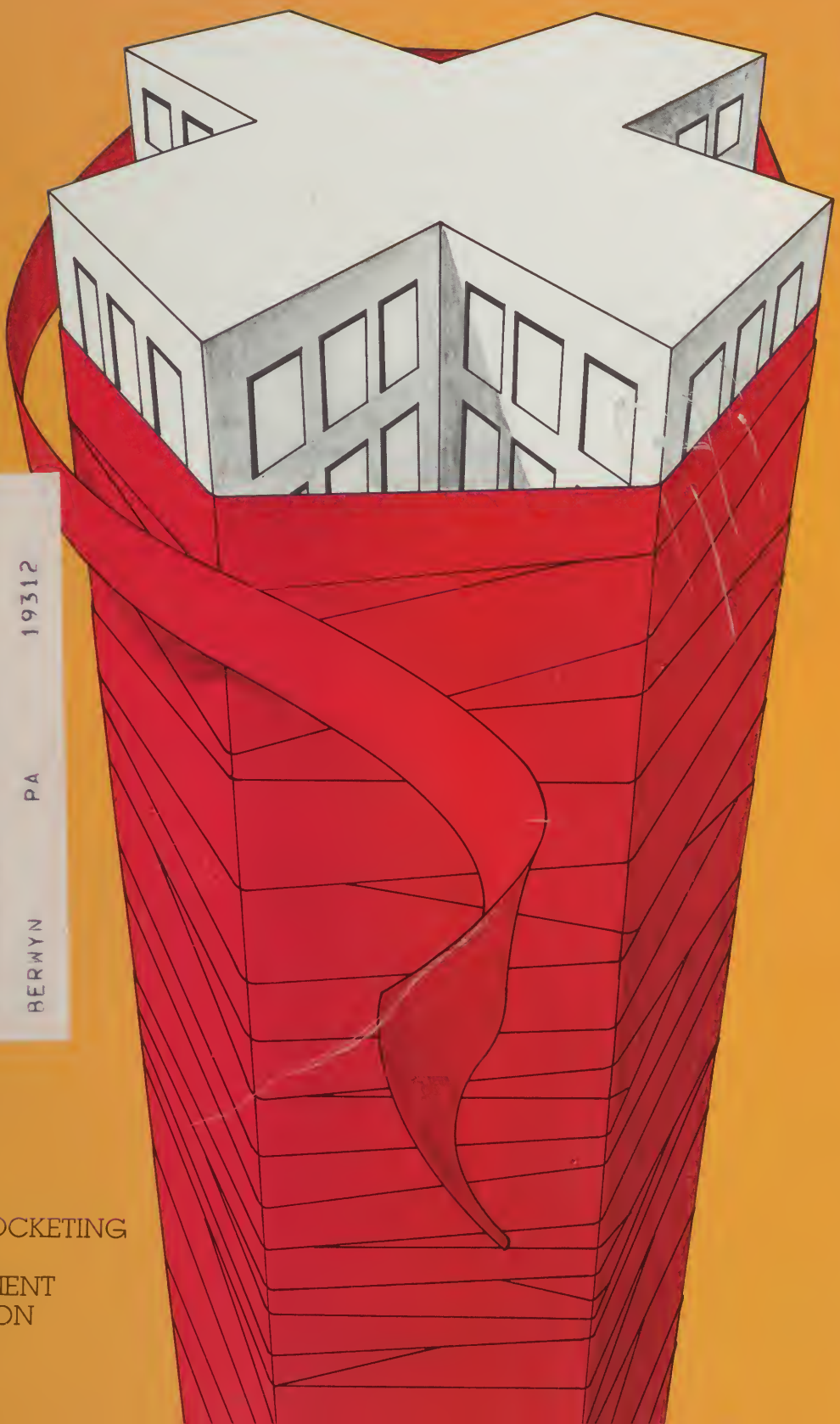

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**Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.**

**You can help minimize "cardiac separation" with a program of counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).**

**Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity. Sublingually, Cardilate begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.**

## counsel & Cardilate® (erythrityl tetranitrate)

**CARDILATE®** (ERYTHRITYL TETRANITRATE)

**INDICATIONS:** Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

**CONTRAINDICATIONS:** Idiosyncrasy to this drug

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety

**PRECAUTIONS:** Intraocular pressure is increased, therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur

**DOSAGE AND ADMINISTRATION**

Oral/Sublingual Tablets. Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed

**HOW SUPPLIED:**

**CARDILATE** (Erythrityl Tetranitrate) TABLETS (Scored)
for ORAL or SUBLINGUAL USE 5 mg. Bottle of 100.
10 mg. Bottles of 100 and 1000. 15 mg. Bottle of 100

Reference 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987, 1970

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# medigram

MEDICAID POSITION PAPER CALLS FOR FEE REFORMS

The PMS Board of Trustees April 9 approved a position paper on medicaid which calls for a fee increase to $15 for a visit of a medicaid patient to a physician's office. Prepared by the Subcommittee on Medicaid of the Council on Medical Economics, the paper calls for a line item in the state's 1981 budget with enough funding to cover the cost for such visits. The position paper quotes a summary paper of the Department of Public Welfare, ". . .the inadequate outpatient fee structure encourages expensive institutional services and discourages less expensive outpatient services." Copies of the position paper are available on request.

Other recommendations in the position paper, which is the base for the Society's current lobbying efforts in the legislature, include:

(1) increasing the entire medicaid fee schedule to the existing medicare surgical and procedure fee schedule;
(2) allowing physicians to bill for performing a required procedure or service along with an office visit;
(3) delaying implementation of the new MA Management Information System until technical problems are eliminated.

DPW PROPOSES FEE INCREASE TO $8 FOR PATIENT VISIT

Under a proposed rule published in the Pennsylvania Bulletin April 19, physicians would receive $8.00 for treating a patient on medicaid rather than the $6.00 which has been in effect since July 1, 1974. A 60-day comment period, beginning April 19, is part of the proposal.

MEMBERSHIP SURVEY SEEKS DATA, MA REFORM SUPPORT

The PMS Board authorized a membership survey, through a presidential letter with a reply card, seeking names of physicians who treat medicaid patients, either without charge or by billing the state. An alliance of physicians and welfare patients then will lobby for first class medical care for all Pennsylvanians. At the PMS Officers' Conference April 23-24 in Camp Hill, representatives of welfare rights organizations appeared on the program urging "joint action in the direction of a single-track system of care for all."

OVER 300 LEARN OF ISSUES AT 1980 OFFICERS' SESSION

Hoyt D. Gardner, MD, AMA president, and U.S. Representative Tim Lee Carter, Kentucky physician and veteran House member, were among speakers outlining national issues at the PMS Officers' Conference April 23-24 in Camp Hill. Some 300 medical society and hospital staff officers heard Secretary of Health H. Arnold Muller, MD, and Secretary of Public Welfare Helen O'Bannon discuss state problems. Details will appear in the June issue.

PLANNING COMMITTEE SURVEY OF PMS MEMBERS DUE IN MAY

All members will receive in May a survey designed to assist the Planning and Evaluation Committee assess members' priorities. Committee Chairman Leroy A. Gehris, MD, PMS president elect, urges members to complete the survey and return it promptly, so that the committee will have the data it needs to recommend future Society activities.

READING RADIOLOGIST ON HEALTH CARE POLICY BOARD

R. William Alexander, MD, former chairman of the PMS Council on Legislation, has been appointed to the Health Care Policy Board, created by the state's new Certificate of Need Law, Act 48 of 1979. He was one of eight gubernatorial nominations to the new board approved recently by the Senate. Three vacancies still exist on the board which held its first meeting April 17.

AD HOC COMMITTEE STUDIES COLLECTIVE BARGAINING

David J. Keck, MD, chairman of the PMS Board of Trustees has appointed a new ad hoc committee to study collective bargaining methods for publicly employed physicians. Serving are Robert S. Pressman, MD, Philadelphia, Chairman; Kenneth L. Cooper, MD, Williamsport; and John J. Danyo, MD, York. The committee will report its findings to the Board.

PSYCHIATRIC CARE RULES VIOLATE PRACTICE ACT

The PMS Board of Trustees on April 9 ordered efforts to change the Psychiatric Outpatient Services Regulations which became effective February 1, 1980. The regulations appear to contravene the Medical Practice Act, the Council on Education and Science reported. The Board reaffirmed the PMS policy on the relationship of physicians with non-physician health care practitioners (see the March issue).

PROFESSIONAL CORPORATIONS BILLED FOR ARBITRATION

The Office of Arbitration Panels for Health Care, which operates Act 111's Arbitration System, has billed professional corporations with Catastrophe Loss Fund coverage $100, the fee paid by health care facilities under the Act. Arthur Frankston, director, said an attorney general's ruling holds that the amendment to permit professional corporations to seek Cat Fund coverage applies the Act to those corporations in its entirety. The physicians so billed also pay the $25 individual provider arbitration fee. See page 11 for details. The Society's ad hoc committee to consider amendments to Act 111 has the matter on its agenda.

Pennsylvania Medicine

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20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

PUBLICATION COMMITTEE
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Medical Editor
Mary L. Uehlein,
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CONTRIBUTING EDITORS
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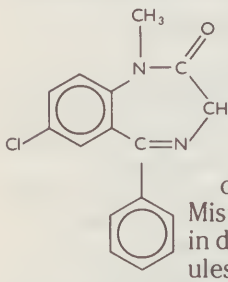
*Aspects of Management*

# What to tell your patients when you prescribe Valium® (diazepam/Roche)

## Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.* Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy. Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

## What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

## What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics,

## Practical pointers on taking antianxiety medications

**do's** Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

**and don'ts** Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

*2-mg, 5-mg, 10-mg scored tablets*

# Valium®(IV)
# diazepam/Roche

## An important adjunct to your treatment program for excessive psychic tension

barbitu-
rates, MAO
inhibitors and
other antidepres-
sants may potentiate
its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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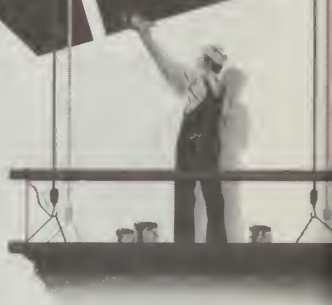
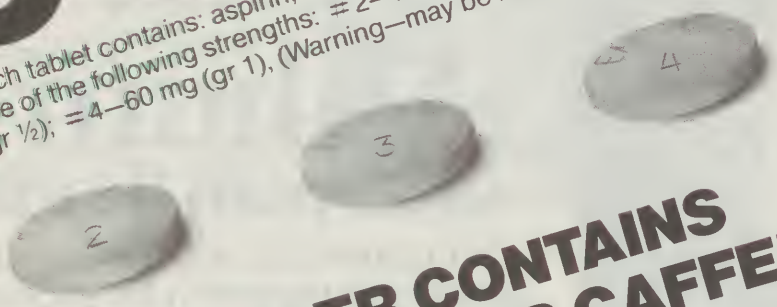


Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg ((gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)

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# editorial

## Skyrocketing cost of government regulations

*Health costs have been a target of many budget-minded bureaucrats . . . a good way to engineer at least some budget reduction is to eliminate the duplication in regulations and regulatory agencies.*

January's 1.4 percent increase in the inflation rate (compound 18.2 percent annual rate) may have been the cold shower that was needed to awaken a bulging bureaucracy to the realities that have been experienced by the average American family for some time. President Carter's call for budgetary cuts and an austerity program are certainly welcome. Congressional action on budget cuts might be slow as the unwillingness to economize in one's own backyard begins to show itself in the voting.

However difficult actual budget reductions become, they should be carried out. This means eliminating duplication, discontinuing costly programs that have little practical value, and adopting a national attitude that looks to the future improvement of the nation's financial status.

At the household level, these economies have become vital. Gas, food, mortgages, and interest rates have forced the average American family to watch the budget much more closely than was necessary in the early 1970s.

Health costs have been a target of many budget-minded bureaucrats and over the years numerous regulations have been enacted in the name of economy. The latest government entry into this arena is the Health Systems Agency (HSA) which is designed to eliminate expensive duplication in providing health care to consumers.

The rallying point for HSAs has been the CT scanner. It is considered duplication and waste for health facilities in the same area to obtain CT scanners. Every scanner denied is applauded as another half-million dollars "saved."

Yet duplication has proved to be a major problem in the regulatory activities of both government and private agencies in their demands on hospitals. In a report entitled *Cost of Regulation* prepared by the Task Force on Regulation of the Hospital Association of New York State, duplicative regulations were cited 467 times in 34 areas. Conflicting regulations were cited 55 times, and non-productive, 34 times.

Other findings of this study revealed that 25 percent of hospital costs are spent to comply with governmental regulations. Translated into dollars and cents, in 1976 this amounted to $40 per day on the average patient bill. The study noted that the annual commitment of 115 million man-hours devoted to regulatory activities translated into 56,000 people, enough to staff 75 hospitals of 250 beds each.

A similar study conducted in Michigan by the Hospital Research and Educational Trust of Chicago, and funded by the Kellogg Foundation, determined that more than $24 was added to the average hospital bill as a result of regulation in 1977. Six hospitals were surveyed on six categories of governmental regulation.

Utilization Review and PSRO programs appeared to cost the most for compliance, between $31,000 and $220,000 in 1977. Certificate of Need laws requiring hospitals in Michigan to undergo review for expansion of service projects in excess of $100,000 cost between $1,700 and $135,865 to gain acceptance. This study also noted that state, federal, local, and other agencies have conflicting or overlapping regulations.

In spite of the findings of these and similar studies, we continue to be told of the savings each of these regulatory agencies effect for the "health care consumer." The inconvenience of the physician, hospital administrator, registered nurse, allied health professionals, and especially the patients, both in time and dollars, seem never to be figured in the savings.

A hospital's expenditure in pursuit of a project approval is not a saving. Time devoted to completing regulatory forms is not productive. Laboratories standing inspection six or eight times a year by different agencies for similar or identical purposes is a waste of time, and an expensive one.

The operating costs of a regulatory agency are often conveniently missed when "savings" statements are being publicized. Salaries, office space, supplies, and consultants must be balanced as well.

A good way to engineer at least some budget reduction is to eliminate the duplication in regulations and regulatory agencies, not only in health but also in other areas. Legislation was intended to aid and protect society but instead, it has grown into a tangle of overlapping and conflicting rules. The tangle snares too many people, and the worst part is, we pay dearly for the privilege of being caught.

David A. Smith, MD
Medical Editor

# How 123 new doctors saved $100,000 in professional liability premiums

They did it last year by taking advantage of PMSLIC's 20% discount on professional liability insurance premiums to all new insureds entering practice in Pennsylvania for the first time.

That's right! A big 20% discount and you still get the same, complete coverage. That's an important saving for new doctors coping with so many other start-up expenses.

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Please send me more information on PMSLIC. I ☐ am ☐ am not a new doctor.

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Address _____

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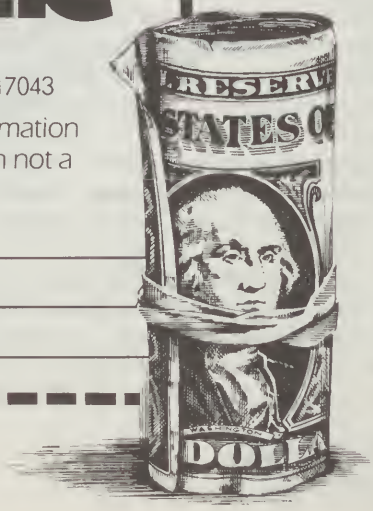

# newsfronts

## Ground broken for PMS headquarters expansion

Architect's model of the expanded headquarters of the Pennsylvania Medical Society

Two dump trucks, a 70 ton crane, a 955 dozer, and mountains of mud surround PMS headquarters.

A $2.7 million expansion has started and when the machinery is no longer needed, an addition which more than doubles the existing space will be complete.

At the groundbreaking ceremony after the Board of Trustees meeting April 9, 1980, David J. Keck, MD, chairman of the board and of the Building Committee, said the occasion marked "the beginning of a new era for organized medicine in Pennsylvania."

The upper floors of the four-story addition will be occupied by the staff of the Pennsylvania Medical Society Liability Insurance Company. Ground floor space will be used for meetings of councils, committees, and commissions.

A five-deck parking garage attached to the addition will provide space for 200 cars. The entire addition makes maximum use of the 2.5 acres that were available to the Society on the site.

When the expansion is completed, some 33,000 square feet will have been added to the headquarters to accommodate 175 employes and 200 cars. This combination should serve the needs of the Society for at least the next 20 years.

## AMA plans English study for foreign-trained MDs

The American Medical Association in July will offer foreign physicians a one-day course in improving English pronounciation.

The course is designed to help foreign physicians now in practice in the U.S. to improve spoken communications with their patients.

Physicians attending the July 26 sessions at AMA headquarters in Chicago will receive formal credits in continuing medical education.

Lectures, practice on producing the sounds of American English, oral drills, individual criticisms, and practice in sustained discourse through reading and extemporaneous speaking will be included.

Elizabeth Lang, professor of English as a second language at Cuyahoga Community College, Cleveland, Ohio, will teach the course. Mortimer Enright, head of the AMA's Speakers and Leadership Programs Section is course director.

Further information on the course is available from Henry Mason, Division of Professional Relations, AMA, 535 North Dearborn Street, Chicago, IL 60610.

# Board receives abortion survey totals

The Pennsylvania Medical Society's all member survey on abortion, ordered by the 1979 House of Delegates, is completed. Of 14,526 cards mailed to members January 3, 1980, a total of 6,452 were returned.

The survey was undertaken after the House of Delegates amended and then adopted substitute Resolution 79-2, which said:

"Resolved, that the PMS policy on abortion be sent to the entire membership through a survey to solicit their opinion on whether they approve or disapprove of the present policy position. This survey should be completed by March 1980 so that results may be analyzed by the Board of Trustees, communicated to the membership, and reported to the 1980 House of Delegates."

The proceedings of the 1979 Annual Meeting continue, "The House approved the amendment to Resolution 79-2 from the floor of the House, instructing that the survey ask the following two questions: Whether or not the respondent approves of the present position of PMS; and whether or not the respondent favors abortion on demand when concurred with in the opinion of the patient's physician. The House adopted the substitute resolution as it was amended from the floor."

A replica of the post card questionnaire appears on this page. The Society's current position on abortion, shown on the replica of the survey card, was originally adopted by the House of Delegates in 1970, and has been reaffirmed by the House at several meetings since that time.

The tabulation of answers to the questions on the survey follows:

Question One. Do you approve of the present PMS position?

Yes — 3,753 (58% of responses received)

No — 2,333 (36% of responses received)

No response — 366 (6% of responses received)

Question Two. Do you favor abortion on demand when concurred with in the opinion of the patient's physician?

Yes — 3,877 (60% of responses received)

No — 2,288 (36% of responses received)

No response — 287 (4% of responses received)

A further breakdown of the survey cards returned appears below.

**Yes to Question 1 and yes to Question 2** — 2,007 (31.1% of responses received)

**No to Question 1 and no to Question 2** — 777 (12% of responses received)

**Yes to Question 1 and no to Question 2** — 1,475 (22.9% of responses received)

**No to Question 1 and yes to Question 2** — 1,553 (24.1% of responses received)

Of the survey cards returned, 9.7 percent, 627 cards, answered only one of the questions. Thirteen cards, 0.2 percent, were returned with no response to either question.

PMS ALL MEMBER SURVEY ON ABORTION

Present Policy of PMS on Abortion (House of Delegates 1970):

1. There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother;
2. There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency; or
3. There is documented medical evidence that continuance of the pregnancy resulting from legally established statutory or forcible rape or incest would constitute a threat to the mental or physical health of the patient;
4. Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and
5. The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

SURVEY QUESTIONS AUTHORIZED BY HOUSE OF DELEGATES

1. Do you approve of the present PMS position (above)? ____ Yes ____ No
2. Do you favor abortion on demand when concurred with in the opinion of the patient's physician? ____ Yes ____ No

## Emergency physicians plan June assembly

The Pennsylvania Chapter of the American College of Emergency Physicians will hold its Seventh Annual Scientific Assembly at the Marriott Hotel, City Line at Monument Road, Philadelphia, Pennsylvania, June 13-14, 1980.

Three tracks will be offered in an attempt to address multiple current issues in emergency medicine. Poisoning, pre-hospital emergency medicine for physicians, and emergency department procedures will be presented during the two-day period.

Application has been made for 14 hours of ACEP Category 1 credit.

The PaACEP annual meeting, open to all members, will be held Thursday, June 12, 1980, at 7:30 p.m. in the Marriott Hotel.

For registration information contact David Blunk, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043, (717) 763-7151.

## Birth, death certificates cost more

Fees charged for birth and death certificates increased for the first time in ten years effective April 1, 1980.

The state health department announced that the new fees for birth certificates will be $4, and for death certificates, $3.

The fee for a wallet-sized birth certificate card will remain at $2, and veterans and their dependents will continue to receive free birth certificates.

Charles L. Hardester, director of the vital statistics division, said the new fees will increase state revenues to an estimated $2.131 million.

# Covered corporations must pay Act 111 arbitration fee

The Attorney General's office has established that any professional corporation, professional association, or partnership which participates in or contributes to the Medical Professional Liability Catastrophe Loss Fund is subject to all provisions of Act 111, the Health Care Services Malpractice Act, including the requirement to pay a $100 annual fee to support the medical malpractice arbitration system.

More than 1,900 professional organizations chose to secure the $1 million umbrella insurance coverage supplied by the CAT fund and take advantage of the 1978 amendments to Act 111.

Arthur S. Frankston, administrator for the Arbitration Panels for Health Care, reports that Act 320 of 1978 amended the original Act and provided that professional corporations, associations and partnerships entirely owned by health care providers which elect to purchase basic insurance coverage are required to participate in and contribute to the Medical Professional Liability Catastrophe Loss Fund.

The amending Act further provided:

> §811. (d) Any professional corporation, professional association or partnership which participates in or contributes to the Medical Professional Liability Catastrophe Loss Fund shall be subject to all other provisions of this act.

Section 304 of the original Act provided:

> §304. Fees Paid by Health Care Providers. —
> (a) The administration of this act shall be funded in part from fees charged to each health care provider practicing in the Commonwealth and payable to the administrator.
> (b) Physicians and podiatrists practicing in the Commonwealth shall be charged $25 annually.
> (c) An annual fee of $500 shall be charged to each hospital with 250 or more beds. An annual fee of $350 shall be charged to all other hospitals. An annual fee of $100 shall be charged to all other health care organizations . . .

Frankston's office raised the issue of whether §811 (d) required assessing the annual fee provided in §304. The Attorney General's office responded "emphasizing that any professional corporation, professional association or partnership which participates in or contributes to the Medical Professional Liability Catastrophe Loss Fund shall be subject to *all other provisions* of the Act. Therefore, a professional corporation, association or partnership which chose to participate in and contribute to the Medical Professional Liability Catastrophe Loss Fund is required by Section 304 of the Act to pay the $100 annual fee applicable to "all other health care organizations."

Some health care providers have asked whether payment of the $100 fee by a professional organization excuses the physician member(s) of the organization from paying the individual fee assessment of $25. Since each professional corporation, association or partnership is considered an entity separate from its owner(s), it is required to pay the $100 fee and each practicing physician is required to pay a $25 fee.

## PMS Credit Union grows, changes loan requirements

The PMS Credit Union held its second annual meeting March 20, 1980. William A. Shaver, MD, president, noted that despite the tight money situation nationwide, the credit union's membership has grown to 728 with assets totaling over $185,000.

Thomas J. Green, MD, was re-elected for a 3-year term to the board of directors, Alex H. Stewart was newly elected for a 3-year term and secretary of the Credit Committee, and David A. Smith, MD, was re-elected for a 3-year term on the Supervisory Committee. Other officers and committee members remain the same.

The board established a new collection policy at its meeting that day and approved a new requirement for loans. Effective immediately, persons requesting loans must have been employed steadily for at least one year or must be CU members for at least six months.

At its February 14 meeting, the board had approved that a minimum share balance of $100 be required before a member can apply for a loan.

## PMS observes high blood pressure month

The Pennsylvania Medical Society will participate in the observance of high blood pressure month in May. The 1980 theme is new opportunities in high blood pressure control.

In keeping with its theme, the Pennsylvania High Blood Pressure Control Program is sponsoring projects geared to increase awareness of high blood pressure and its control.

The American Heart Association, Pennsylvania Affiliate and the Pennsylvania Pharmaceutical Association will conduct a statewide pharmacy blood pressure screening day on May 10.

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# PaMPAC board reorganizes, elects officers

The board of the Pennsylvania Medical Political Action Committee (PaMPAC) met March 5 to reorganize.

PaMPAC officers for 1980 are: J. Preston Hoyle, MD, chairman, Lewisburg; Norman Goldstein, MD, vice chairman, Phoenixville; William D. Lamberton, MD, treasurer, Erie; Mrs. John H. Eves, secretary, Doylestown; Mrs. Harry E. Serene, assistant secretary, Pittsburgh; and Paul S. Friedman, MD, executive committee-at-large, Elkins Park.

Elected to the 1980 board of directors are: First Councilor District, Paul S. Friedman, MD, Elkins Park; Second Councilor District, Norman Goldstein, MD, Phoenixville; Third Councilor District, Dominick A. Cruciani, Jr., MD, Scranton; Fourth Councilor District, Norman L. Ekberg, MD, Danville; Fifth Councilor District, W. Minster Kunkel, MD, Harrisburg; Sixth Councilor District, J. Reed Babcock, MD, Bellefonte; Seventh Councilor District, J. Preston Hoyle, MD, Lewisburg; Eighth Councilor District, William D. Lamberton, MD, Erie; Ninth Councilor District, Philip LaVerde, MD, Oil City; Tenth Councilor District, Harry E. Serene, MD, Pittsburgh; Eleventh Councilor District, John F. Weldon, MD, Charleroi; and Twelfth Councilor District, Stanley C. Ushinski, MD, Kingston.

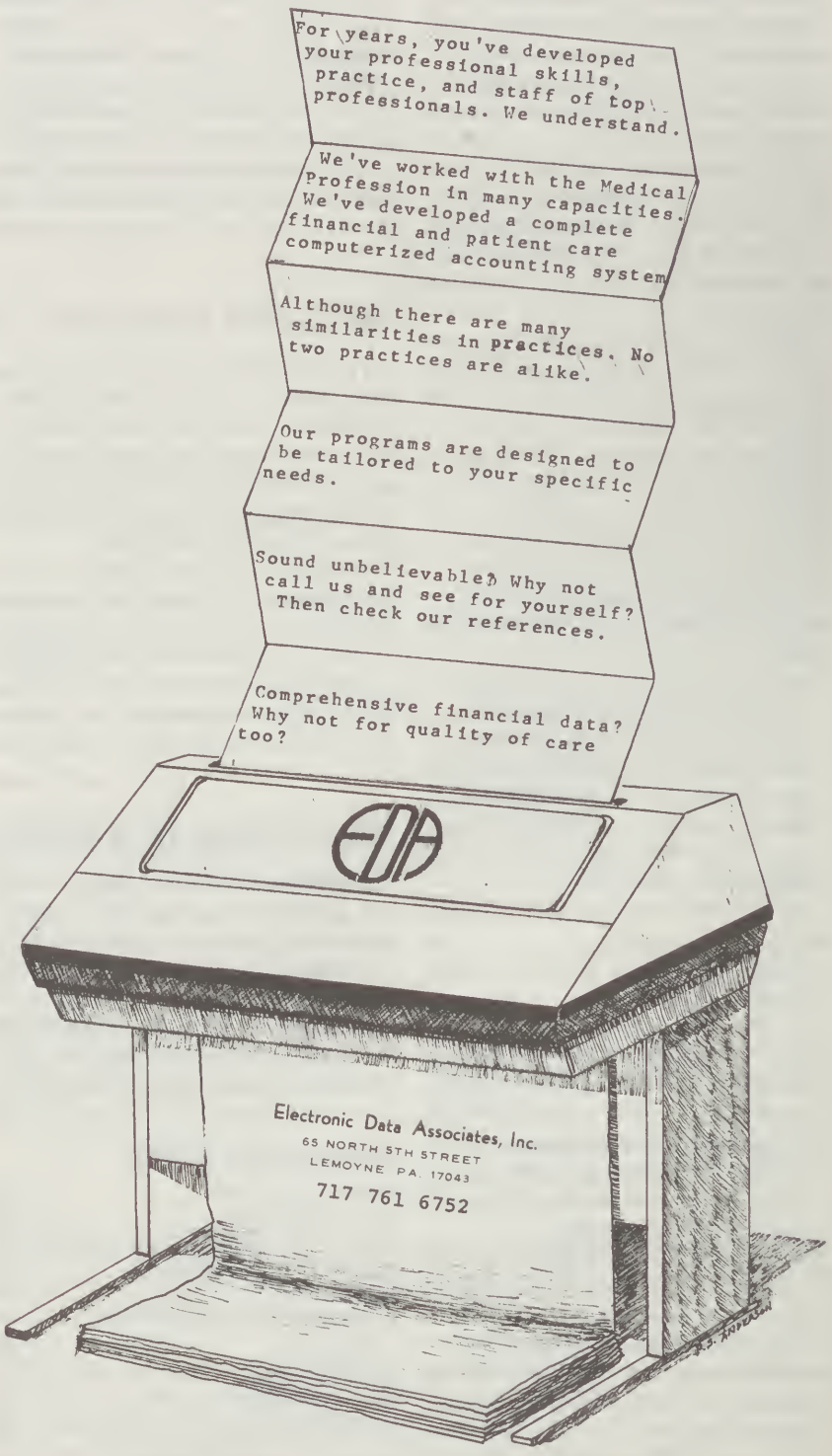
PaMPAC board members-at-large are: Patrick H. Hughes, MD, Braddock; Alan L. Dorian, MD, Norristown; Conrad A. Etzel, MD, Brookhaven; H. Keith Fischer, MD, Philadelphia; Charles D. Saunders, MD, Bethlehem; Mrs. John H. Eves, Doylestown, eastern region; Mrs. Robert E. Brown, Lancaster, central region; and Mrs. Harry Serene, Pittsburgh, western region.

## FTC drops investigation of plastic surgeons

The Federal Trade Commission announced March 3, 1980 the close of its investigation of the American Society of Plastic and Reconstructive Surgeons.

In early 1977, the FTC had threatened litigation against the society for supporting board certification in plastic surgery. The society contended that board certification was critical in maintaining quality care in plastic surgery.

Peter Randall, MD, past president of the society, said the FTC's decision was based on the "solidarity and support" demonstrated by medical colleagues. According to Dr. Randall, "The FTC's attempt to reduce costs by advocating lowering the quality of medical care through its attempts to downgrade the importance and value of board certification was clearly ill-advised."

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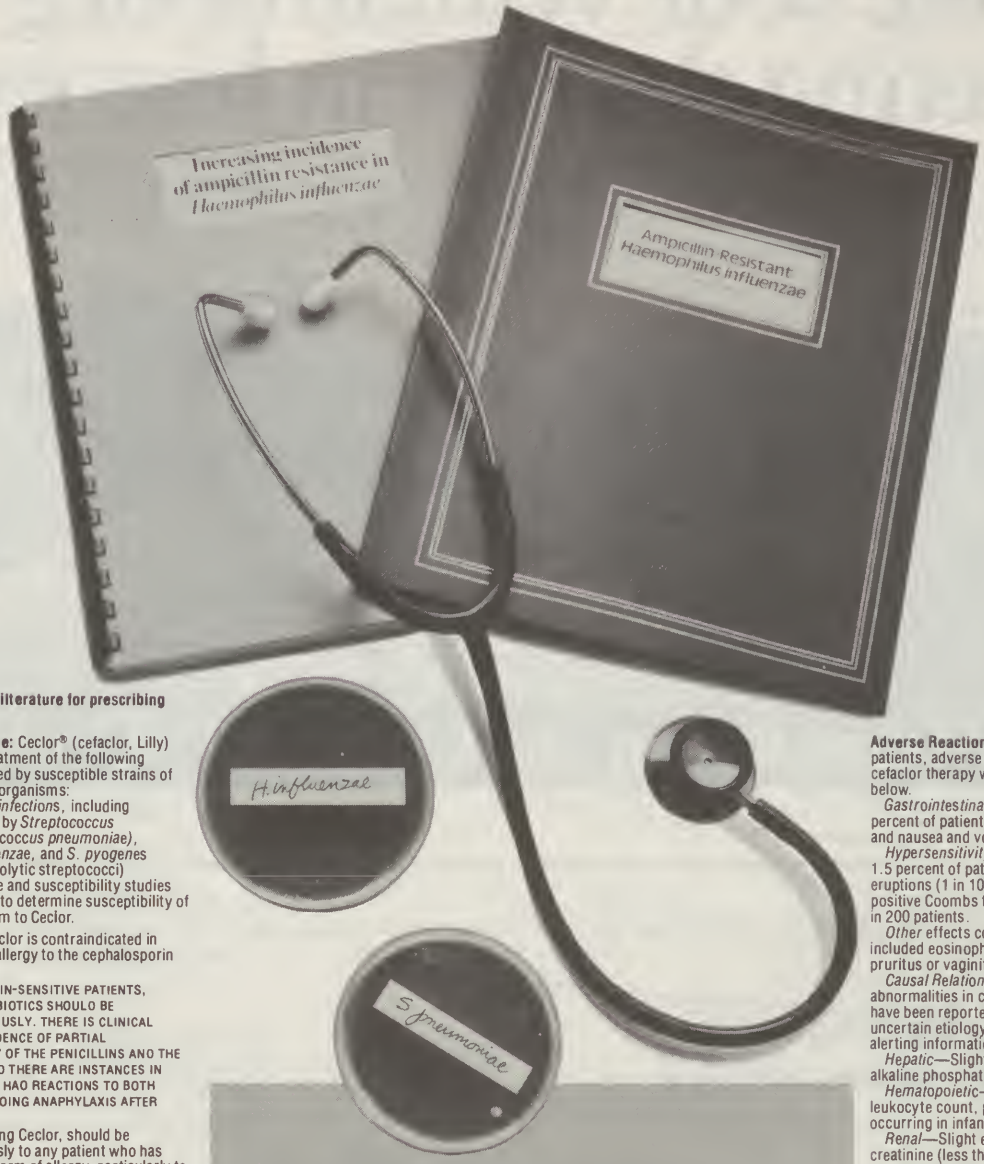
# An added complication... in the treatment of bacterial bronchitis*




**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.**[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

**Ceclor®**
**cefaclor**
Pulvules®, 250 and 500 mg

**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage:** Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note:* Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.*

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# Act 111 limitations on attorneys' fees challenged

**Fred Speaker, Esq.**

A lower court decision has ruled that the limitation on the amount of attorneys' fees charged in medical malpractice cases is unenforceable. Judge Stanley M. Greenberg issued the ruling October 2, 1979.

The decision came in the case of *Marquez v. Hahnemann Hospital*[1] on the provision of Act 111, the Health Care Services Malpractice Act,[2] which says that plaintiffs' attorneys must charge less than certain stipulated amounts under contingent fee agreements. Section 604 of Act 111 states:

> When a plaintiff is represented by an attorney in the prosecution of his claim the plaintiff's attorney fees from any award made from the first $100,000 may not exceed 30 percent, from the second $100,000 attorney fees may not exceed 25 percent, and attorney fees may not exceed 20 percent on the balance of any award.[3]

The case involved a dispute involving a petition filed by the attorney for the plaintiff, a minor, for approving the settlement of the case and authorizing the payment of a third of the settlement as fees for the attorney. The administrator of the Arbitration Panels for Health Care refused to approve such an amount for attorney's fees because it exceeded the statutory limit.

The court held that this refusal was in error because the statutory limitation was suspended, pursuant to another statute which provided that:

> so long as said rule promulgated by the Pennsylvania Supreme Court shall be operative, the operation of any act of Assembly relating to practice or procedure in such courts, and inconsistent with such rule, shall be suspended insofar as such act may be inconsistent with such rule.[4]

This quoted statute was repealed effective June 27, 1978, more than a year before the decision, and was replaced by a statute which does not include the quoted language.

The Judicial Code does state that the Supreme Court has the power to prescribe general rules governing:

> Practice, procedure, and conduct of all courts . . . if such rules are consistent with the Constitution of Pennsylvania and neither abridge, enlarge, nor modify the substantive rights of any litigant . . . All statutes shall be suspended to the extent that they are inconsistent with rules prescribed under this paragraph.[5]

Rule 2039 (b) of the Rules of Civil Procedure, adopted by the Pennsylvania Supreme Court, provides that "the court may make such order as it deems proper fixing counsel fees" in approving a settlement involving a minor.

Judge Greenberg concluded his opinion with the following statement:

> Insofar as Section 604 conflicts with this court's power under Pa. R.C.P. 2039 respecting a fair contingent fee in a minor's case, we hold that the section is "suspended." It may be felt that this result will lead to a difference in treatment between adult and minor plaintiffs. But such a difference has existed in law from time immemorial. The minor plaintiff's guardian in this case will thus be responsible for a higher fee than would an adult plaintiff. Higher, but certainly not unfair in terms of the customary practice and procedure in the Court of Common Pleas of Philadelphia County.
>
> Since we are admonished to avoid the constitutional issue if possible, we do so in this case in finding Section 604 "suspended" *in the context of this case* as inconsistent with the rule vesting minor's compromises exclusively in the Court of Common Pleas.[6]

The significance of the *Marquez* case is not in the holding described but rather in the statements of Judge Greenberg about the unconstitutionality of the statutory limitation on the amount of contingent fees that may be charged by a plaintiff's attorney. Judge Greenberg stated:

> On the whole, it would be generally accepted today that such arrangements have been salutory to the administration of justice for without them none but the very wealthy could afford counsel in civil cases involving personal injury or other civil wrong.[7]

He expressed the view that the limitation on fees might contravene provisions of the Pennsylvania Constitution requiring separation of powers[8] and the right of an attorney to earned fees.[9]

Judge Greenberg stated that the limitation also may violate the constitutional requirement of equal protection:

> In practical terms, this statute appears to establish unequal and insidious classifications. First, Section 604 classifies the attorney for the plaintiff differently from the attorney for the health care provider by singling out plaintiff's attorney for a special limitation on the fees he may receive with no comparable mention as to the fees defense counsel may receive. Second, plaintiffs are treated differently from defendants since the contractual relationship between plaintiff and his or her attorney is circumscribed while total freedom of contract is permitted between health care provider and attorney. Third, Section 604 fixes a sliding scale devoid of any logical relationship to the time and labor required, the novelty or difficulty of the questions involved, that the case may be tried and retried, that appeals may be taken, and that even after all these services have been rendered there may be no money judgment for plaintiff. These are the hazards an attorney assumes when he accepts a client on a contingent fee basis.

Even if we assume that regulation of attorneys' fees constitutes a rational ground for bringing costs of malpractice into line, this justification seemingly provides no explanation for the differential treatment of plaintiff's attorneys as distinguished from those representing

---

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*

health care providers.

Not only does there appear to be lacking a reasonable basis for drawing a distinction between plaintiff and defendant attorneys by singling out the one, but the fees a plaintiff incurs may not constitute a rational basis for resolving the so-called "malpractice crisis." In fact, the contingent fee structure may *actually compel* plaintiffs' attorneys to screen out claims which are spurious or for which recovery appears less than probable.[10]

This decision, if left unchallenged, may give rise to a direct, specific attack on the constitutionality of statutory limitation of the attorneys' contingent fees.

*1.*/ No. 1246 Dec. Term, 1977 (Phila. October 2, 1979).
*2.*/ 40 P.S. §§1301.101 *et seq.*
*3.*/ 40 P.S. §1301.604.
*4.*/ 17 P.S. §61 (repealed).
*5.*/ 42 Pa.C.S. §1722(a) (1).
*6.*/ *Marquez v. Hahnemann Hospital, supra* at 27.
*7.*/ *Id.* at 13.
*8.*/ Pa. Const., Art. 5, §1; Art. 5, §10(c).
*9.*/ Pa. Const., Art. 1, §1.
*10.*/ *Marquez v. Hahnemann Hospital, supra* at 21-2.

## Court disallows negligent informed consent pleas

**Fred Speaker, Esq.**

Does a physician who does not know all the substantial risks in prospective surgery and therefore does not tell the patient of those risks give rise to a cause of action called "negligent informed consent?" A recent decision by the Philadelphia Court of Common Pleas answers "no."

In the *Isard* case the patient sued for damages, alleging that he suffered a perforation during an esophageal dilation. The complaint set forth specific acts of negligence. During his deposition the physician was asked what conversations he had with the patient, and did he tell the patient "what you were going to do, what you were hoping to accomplish, and what risks, if any, were entailed?"[2] The physician:

> revealed that he was unable to state with certainty that he had informed the Plaintiff of all the substantial risks involved in the type of surgery to be performed, or, further, that he had even been aware of all such risks.[3]

On the day listed for trial the court was asked whether the issue of informed consent could be submitted to the jury. The counsel for the physician argued that it could not because it was not pleaded and to plead it now would be barred by the statute of limitations.

The patient's counsel argued that it could be submitted because the case:

> involves a doctor who allegedly admitted not only to a failure to inform his patient with regard to certain possible risks, *but to having been ignorant of the fact that such risks existed.* The failure to inform a patient under these circumstances, contends the Plaintiff, does create a cause of action sounding in negligence.[4]

The Court disagreed with the plaintiff's argument:

> The Plaintiff's theory is that a failure by the doctor to possess knowledge of the appropriate risks would remove the doctrine from intentional tort and create a cause of action akin to negligent informed consent. This theory is without merit. A failure by a surgeon to maintain sufficient familiarity with the risks prevalent in his speciality and thereby relate to a failure to meet the standard of care required. This is not to say, however, that the nature of an action premised upon a battery, or unlawful touching, would be transformed thereby into one based upon negligence. An informed consent action is premised upon a failure by the physician not merely to *know* of the risks involved, but a failure to *communicate* those risks to his patient. It is this failure to communicate that distinguishes the causes of action.[5]

Thus the Court preserves the distinction between negligence or malpractice and damages for the failure to obtain informed consent.

*1.*/ *Isard v. Atkins et al.*, 2 P.C.R. 633 (Phila. 1979).
*2.*/ *Id.* at 636.
*3.*/ *Id.* at 636-7.
*4.*/ *Id.* at 638.
*5.*/ *Id.* at 641-2.


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**CONTRAINDICATIONS** Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined:

*General:* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

*Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles.

*Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis.

*Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

*Gastrointestinal System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

*Genitourinary System:* Urinary frequency, difficult urination, urinary retention, early menses.

*Respiratory System:* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

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# physicians in the news

The PMS Board of Trustees at its February meeting nominated **Jonathan E. Rhoads, MD,** for the AMA's Sheen Award. In his 48 years in medicine, Dr. Rhoads has served the profession in numerous leadership positions at all levels. He has received numerous honors and awards, including the American Cancer Society National Award in 1973 and the Modern Medicine Award for Distinguished Achievement in 1974.

**James C. Cobey, MD,** has volunteered as physician-in-charge at Camp 204 on the Thai-Cambodian border. Dr. Cobey, a Washington orthopedic surgeon, is with a 25-member Red Cross medical team treating refugees.

**Francis A. Lovecchio, MD,** recently was elected to a one-year term as vice president of the Pennsylvania Orthopedic Society. Dr. Lovecchio, an orthopedic surgeon in East Stroudsburg, has been on the staff of Pocono Hospital since 1966.

**Carl Teitelbaum, MD,** has been named medical director of the cancer screening and detection clinics at Valley Crest, Wilkes-Barre, and St. Joseph Hospital, Hazleton.

The PMS Board of Trustees recently honored **David A. Smith, MD,** for his ten years as medical editor of PENNSYLVANIA MEDICINE.

Dr. Smith is medical director of Polyclinic Medical Center, Harrisburg. He is past president of the Dauphin County Medical Society and has been a member of the PMS House of Delegates since 1971.

He is the voice of the Pennsylvania Medical Society in the weekly broadcast of "Today's Health," a radio program on 62 stations statewide.

American Legion Post 515 of Latrobe honored **F. Clay Gibson, MD,** with its annual Community Service Award.

**Francis A. Salerno, MD,** is the first blind physician to have passed the certifying examination of the American Board of Internal Medicine. Dr. Salerno, whose blindness resulted from diabetes after he had completed his internship at Reading Hospital, now is on the medical staff at Reading Hospital and Medical Center.

**Lewis W. Bluemle, Jr., MD,** president of Thomas Jefferson University, has been elected to the board of directors of Narco Scientific, Inc.

**Donald G. Crawford, MD,** has been named the recipient of the $500 William H. Seibert Prize of the Dauphin County Medical Society. Dr. Crawford, president of the society and chairman of its board of governors, is a medical staff physician with the departments of family medicine at Harrisburg Hospital and Polyclinic Medical Center.

**Frank E. SanGiorgio, MD,** Altoona, and **Carlos H. Castellon, MD,** Johnstown, have been named co-chairmen of the Public Affairs Committee of the Pennsylvania College of Emergency Physicians.

Four York County physicians recently received citations for 50 years of service. From the 1930 class of Jefferson Medical College are **Drs. Oren W. Gunnet, Paul M. Reigert,** and **Wallace E. Hopkins,** all in family practice. **Kenneth L. Benfer, MD,** another honored physician and York County native, is a medical missionary now in China.

Mercyhurst College, Erie, has named **George J. D'Angelo, MD,** to its board of trustees.

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

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# Indochinese refugees pose new health problems

**Mary Ann McCarthy, RN**
**Ernest J. Witte, VMD, MPH**
**Robert D. Gens, MD**

The United States has agreed recently to increase to 14,000 per month the number of Indochinese refugees accepted for resettlement. Before a refugee is granted a visa, health screening includes a cursory physical examination, a chest x-ray for those over 2 years old, and a serologic test for syphilis for those over 15 years old.[1]

Surveillance data indicate that most refugees will be free of major contagious diseases and that the main health problems will include tuberculosis and parasitic diseases.

Pennsylvania has about 10,000 Indochinese residents, about 1,800 of whom have arrived in the past 21 months from rural areas of Vietnam or Cambodia. These newer arrivals have a high incidence of tuberculosis disease.

Southeast Asians seek family members upon arrival in the state. Although Southeast Asians are dispersed throughout the state, large clusters of families live in Philadelphia, Chester, Lancaster, and Lebanon counties.

**Services**

Health care services available to the refugees through the Pennsylvania Department of Health include three main areas: tuberculosis, sexually transmitted diseases, and immunizations.

Tuberculosis skin testing and treatment for active disease and prophylactic INH therapy are available.

In the area of sexually transmitted diseases, follow up care for those treated before entering the U.S. and diagnosis and treatment of symptomatic individuals are available. Complete series of immunizations are included for children; for adults Tetanus-diphtheria (Td) according to routine series is available.

*The authors are active in the Bureau of Epidemiology & Disease Prevention of the state health department.*

**Infectious diseases**

The following infectious diseases represent the more significant problems which the private physician may encounter.

**Malaria** — Chloroquine-resistant *P. falciparum* is endemic in Southeast Asia. We recommend thick and thin blood films be done on refugees presenting with a history of fever, and anemia, splenomegaly, chills, headache, backache, or malaise. All *P. falciparum* infections should be considered resistant. An estimated 10 percent of refugees have G-6PD deficiency; screening for this deficiency is recommended before beginning Primaquine treatment.[2]

**Parasitic infections**—Other than malaria, parasitic infections include hookworm, Giardia, Trichuris, and Ascaris. These are the most common intestinal parasites found in Indochinese refugees. Routine screening for intestinal parasites is not necessary but individual testing of those requiring medical care is recommended.[3]

**Hepatitis B** — Preliminary data from screening of Indochinese refugees entering Canada indicate that about 12 percent are positive for Hepatitis B surface antigen (HBsAg). Most of these individuals are asymptomatic, chronic carriers of the antigen. There may be some increased risk of transmission to adopting and host families but the greater likelihood of transmission is to neonates (during childbirth), and certain health-facility personnel.

We recommend that HBsAg status be determined on all pregnant women and all Indochinese admitted to hospitals. Neonates of HBsAg positive mothers should receive hepatitis B immune globulin (HBIG) or immune serum globulin (ISG) as soon as possible after birth. In the hospital setting, proper handling of blood and other body fluids of HBsAg carriers is imperative.

To prevent possible exposure, dental personnel may consider wearing gloves, face masks, and eyeglasses when treating HBsAg carriers.[4]

**REFERENCES**

1. Center for Disease Control Morbidity and Mortality Weekly Report, Health Status of Indochinese Refugees *MMWR 28*:385-386, August 24, 1979.
2. *MMWR 28*:388-395, August 24, 1979.
3. *MMWR 28*:395, August 24, 1979.
4. Health Status of Indochinese Refugees: Malaria and Hepatitis B, *MMWR 28*:464-470, October 5, 1979.

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# Medical malpractice — a system run amok

J. Joseph Danyo, MD

Much has been written about medical professional liability in the last few years. Events leading to the crisis continue to be culled. This article offers an analysis of those hectic times and an insight into this complex societal problem.

**Definition**

Medical malpractice has a multifaceted etiology. Much confusion reigns in the minds of doctors and the public as to what malpractice really is. It applies to architects, embalmers, lawyers, doctors, and other professionals. For physicians malpractice refers to reprehensible misconduct toward a patient. It is bad, wrong, and injudicious therapy resulting in injury and proceeding from ignorance, carelessness, lack of skill, disregard of standards of care, and malicious or criminal intent.

In order to prevail in a malpractice action a patient and his attorney must show: a legal duty due; a breach of that duty; a proximate causation; a harm; and an absence of contributory negligence by the patient. The duty owed the patient is the standard of care for the specialty and how a reasonable physician would perform under the circumstances of the case.

A bare handful of practitioners grasp these legal precepts. That is a good part of the problem. All too often doctors use the term inappropriately. A poor or compromised result may be one of the elements of negligence. It is up to a lawyer and a lawyer only to establish malpractice.

**Crisis**

Prior to fifteen years ago Americans perceived their doctors with god-like awe. The advent of rampant specialization and super specialists, the emergence of high powered technology, and the accompanying glut of medical sophistication caused a fragmentation of care.

These new technological advancements produced dramatic results and the desire for a perfect outcome each time. Every new marvel has its share of side effects and negatives. Add a highly mobile populace and a changed picture of a physician/patient relationship appears. Altering the traditional bond to a parcel of care for specific conditions is now commonplace.

Then, too, more and more people became covered by hefty insurance plans. This allowed broader access to the system. Hospitals, with federal urging during Great Society days, enlarged dramatically. Progressive care units and armies of specially trained nurses and technicians blossomed to provide the best.

In this milieu humanism suffered. Often the patient left the hospital as a finished product rather than as a human being. He was caressed and handled by scores of assemblers for brief moments. The feeling of depersonalization was aided by contact with many worker bees with different personalities and utterances.

This is the system today. This seeming lack of caring occurred at a time when people were becoming more litigious. This climate bred suspicion and hostility especially when the desired result was not achieved. Thus, the unhappy patient, for whatever reason, often sued.

The seeming inability "to get answers" prompted many to seek legal advice. Until recently most lawyers refrained from getting involved in these cases. The demise of charitable immunity for hospitals, the publicity afforded occasional million dollar awards, the notion that the doctor's insurance company was the real target, and the development of court rules allowing recovery to occur more readily whetted the appetite. Many attorneys now specialize in this area.

For many years hundreds of insurance companies wrote medical malpractice coverage. Many of them "threw in" this line as part of a multiperil package. A substantial increase in claims in the late 60s coupled with publicity surrounding unusual cases brought the realization to the carriers that under reserving and an inadequate premium structure existed.

The "long tail" in professional medical liability made IBNR (incurred but not reported losses) quite difficult to predict. Great anxiety ensued. Paper losses of fifty percent and more during the recession of the mid 70s were the last straw. Most of the carriers simply folded their tents or demanded such exorbitant rate hikes that a crisis of insurance availability developed.

A flurry of legislative activity followed and professional organizations and medical societies spawned captive insurance companies to meet the needs of members.

**Today's climate**

Mandatory pre-trial screening panels and arbitration mechanisms have been successful in shielding public disclosure of suits. The problem seems to have evaporated; but, nothing could be farther from reality.

After a brief downturn in 1976-1977, the number of claims has begun to escalate. Medical malpractice is volatile and cyclical. This turnabout in litigation is expected to gain momentum as lawyers become more acquainted with the recent tinkering. Other factors also point to another crisis beginning as early as 1981.

Some neophyte captive carriers began offering dividends, rebates, and premium reductions after enjoying a few months of prosperity. Such wishful thinking does not forebode well for the future. Several can be expected to go under from such imprudent action.

The captive companies provided a market for insurance for all. The new apparent stability has encouraged a few commercial diehard companies to consider re-entering the field and others to consider enlarging their portfolios. Competition prevails again thereby creating premium reductions. Some captives whose narrow base cannot tolerate the new marketplace are expected to die on this basis alone.

**Education**

All doctors must know their legal

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*Dr. Danyo is vice chairman of the Pennsylvania Medical Society Liability Insurance Company and Fifth District Councilor on the PMS Board of Trustees. He practices orthopedic surgery in York.*

duties to patients. The rules are ever changing. Too often continuing education courses stress innovative modalities of therapy and new and rare diseases. The explosion in patients' rights and concomitant legal requirements has not been adequately addressed by medical schools, other medical teachers, and providers.

Most physicians don't know what the law is. Actually they are bombarded with a barrage of new agency regulations (medicare, welfare, disability), insurance jousting, continuing education requirements and yes, court decisions that affect their specialty. Only the heartiest can digest the paper blizzard.

Specialty organizations, to which most physicians belong, have been slow in retooling their educational offerings. While alarm and concern exist, the necessary protocol for making limited lawyers of doctors remains to be forged.

Doctor and hospital insurance companies are making strides to educate their members. Risk management seminars and pamphlets are available. Certain journals carry sections devoted to medical liability cases of interest in that particular specialty. The AMA and a few lawyers and doctor-lawyers publish national newsletters detailing cases and their implications.

With time, the captive insurors will make the biggest breakthrough in containing the malpractice ogre. For them, claims prophylaxis means survival. Look for actual office evaluation of the doctor's legal delivery of health care. Correspondence courses with incentives for successful completion are in the offing. Hospitals and doctor captives are destined to change the delivery of medical care to a point previously unimagined.

**Documentation**

A good deal of chagrin lies in documentation deficiencies. The business of medicine is deciding. Doctors decide one thousand times a day and more. Of necessity these decisions often are reached without complete information. Mistakes are inevitable.

Increasingly there is the need to document the mental processes used in reaching these determinations. The doctor is simply too busy to write down all that goes on in his cerebrum, while with the patient. It seems that the higher the degree of specialization the greater the requirement for written notes.

Notations of telephone conversations with the patient and family and the whys and why nots are normally left out of the record. Mini-recorders are used by many doctors but not to the extent necessary. In short, each doctor records only what he feels is necessary for him to diagnose, treat, and followup each patient.

Medical experts testify as to their own idiosyncrasies in record keeping. Their way is the only way. It is easy to second guess several years later when the problem has matured.

In hospitals where the exposure is highest and the outcome is more apt to be pronounced, the simple tool of dictating daily notes is absent. Administrators are loathe to spend the money improving this vital area of communication in patient care.

Doctors' writing is often indecipherable. This leads to errors of omission and translation. The record, or lack of it, enters substantially into all phases of a negligence action.

Medical staffs must push to correct this glaring deficiency by using readily available mechanical devices. Here is one important item that demands attention. Lawyers argue the written record. Anything not in writing is hearsay.

By and large the average physician conducts his practice verbally. Patients are treated as friends and neighbors rather than as potential adversaries. Times have changed. The record is now looked upon with reverence as the only vehicle for retrospectively evaluating the quality of care.

**Cost containment**

Contrary to popular belief, doctors do not order enough tests or consultations. A growing number of claims cite failure to diagnose and not doing enough to diagnose and treat.

For the patient, more means increased health costs. The primary mission in medicine remains the best care for all, irrespective of cost. Doctors must treat everyone royally.

Cost containment is no panoply. Current emphasis on cost control has no application when it comes to compromising any portion of patient care.

Our country is flirting with so-called health maintenance organizations. This is a misnomer. HMOs do not maintain health. Rather they are pre-paid insurance companies whose emphasis is on holding down costs by reducing the number of tests, consultations, and hospitalizations. This may be well and good so long as the patient is not shortchanged in care.

A potential hotbed for suits exists with HMOs, for the concept appears to run at odds with the current emphasis on quality care at any cost. The next spiral in malpractice claims may well seize on deficiencies in this delivery system. Recently a Senate Finance Committee staff report stated "The HMO has a financial incentive to provide less services (perhaps even less than should be provided) in order to keep a higher portion of revenues from premiums."

**Changes**

The malpractice crisis period changed medicine to a considerable extent. The effects are felt daily by physicians. The awareness of fallability, limits of ability, and accountability are salutary and at the same time expensive.

A substantial portion of today's health budget is directly attributable to malpractice fever. Now doctors know they must become more thorough and caring.

Zebra medicine abounds especially among specialties. When one hears hoofbeats, he thinks of zebras (rare entities) first. A whole host of lab tests, many of which are exotic, is part and parcel of the zebra armamentarium. Increased hospitalizations and consultation are other elements of the zebra mentality.

Common sense and experience don't lend themselves well in the record. Lab tests do. Doctors are beginning to realize that more secretaries and typewriters are regarded as part of good medicine. When this idea catches hold on all practitioners, costs will zoom. In Pennsylvania alone, empiric medical legal therapeutics probably costs hundreds of millions of dollars yearly and is steadily rising.

Not all elements of the malpractice puzzle are easily identifiable. For example, some practitioners of dubi-

ous quality manage to escape suits while others of high standing and performance seem to attract legal attention. Certain cities and institutions are afflicted more so than others.

There are risk specialties, especially in surgery. Here, too, a small number of practitioners appear to generate the bulk of the claims, yet other doctors within that group and experiencing similar outcomes manage to avoid litigation.

**Courts**

Equally confusing is the role of attorneys and jurists. The competence of the majority of trial lawyers has been questioned repeatedly by no less an authority than Chief Justice of the United States Supreme Court. Time and again medical malpractice suits have produced poorly founded and ill-prepared cases.

The doctors caught in these scenarios react strongly. Extra cautious and defensive, i.e. zebra, tendencies develop and are implemented permanently in future patient relationships. Thus, unwarranted suits have polarized the profession.

The rush to court has caused a deviation in the delivery of care. Each new court ruling alters the standard. Thus, new requirements for handling various medical problems are flashed to the medical community on a daily basis. All patients foot the bills of the nonmeritorious suits.

The injury to society and the acceptance of clumsy and poor legal delivery by the judiciary have doctors riled. This introduction to the system has convinced many that justice is a mirage.

A recent study at Case Western Reserve University showed that a majority of physicians have been involved in the litigation process. There are no winners, only survivors. This climate of mistrust also has invaded the physician/patient relationship.

**Conclusions**

Medical malpractice suits continue to increase despite an apparent end to the crisis. Recent legislation is not expected to thwart the tide.

Obvious cases of negligence, and documentation and communications deficiencies are the chief causes of courtroom confrontations with patients.

Doctors exhibit a startling lack of knowledge of law as it applies to all facets of patient care. It is up to the captive insurance companies to remedy this educational deficit.

Empiric medical legal therapeutics, often termed defensive medicine, is medicine's response to court rulings and publicity surrounding cases. EMT exacts billions of dollars yearly in health costs as doctors seek to "paper the records."

More documentation is urged to counter the malpractice phenomenon. Additional incentives to practice defensive medicine include the threat of higher insurance premiums and licensing sanctions.

Attorneys and judges must share some of the responsibility for today's lament. Doctors see a system run amok. The chasm between medicine and law runs deep. Society deserves to have these disciplines working for the common good. The erosion of confidence sweeping the country and affecting all persons and institutions is a part of the malpractice picture.


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Case report

# Axillary artery rupture with dislocated shoulder

**Mojy Kia-Noury, MD**

Rupture of the axillary artery complicating dislocation of the shoulder generally is considered a rare clinical entity. In a review of 500 shoulder dislocations, Rowe did not mention arterial injury.[1] Stener collected only 12 documented reports of complete severance of this artery incident to dislocation of the shoulder.[2] DePalma had seen one case of axillary artery rupture following a similar injury.[3] Rob and Henson reported separately a case of ruptured axillary artery with successful result from end-to-end anastomosis.[4, 5]

Absence of pulse at the wrist following a shoulder injury indicates interruption of arterial blood flow due to an injury to a major artery. The type of injury to the artery varies from complete severance, to laceration, compression, or rupture of the intima without any obvious external damage to the artery.

Theoretically extensive collaterals prevent the circulation of the upper extremity from being endangered by ligation of the axillary artery. In fact, practical results in aged patients indicate that circulation is compromised from the original trauma, the reduction, the operation, and the pressure exerted by the hematoma.[6]

Possible involvement of a major artery in shoulder injuries and the need to restore blood flow by direct vascular surgery prompted the reporting of the following case diagnosed clinically and by preoperative arteriogram.

## Case report

A 70-year-old woman injured her left shoulder at 8:30 a.m. on September 22, 1978. Less than one hour later, C.J. DePaula, MD, the orthopedist, examined her at Northeastern Hospital. He found a dislocated left shoulder, a pulseless upper extremity, and a cold, numb, and cyanotic hand.

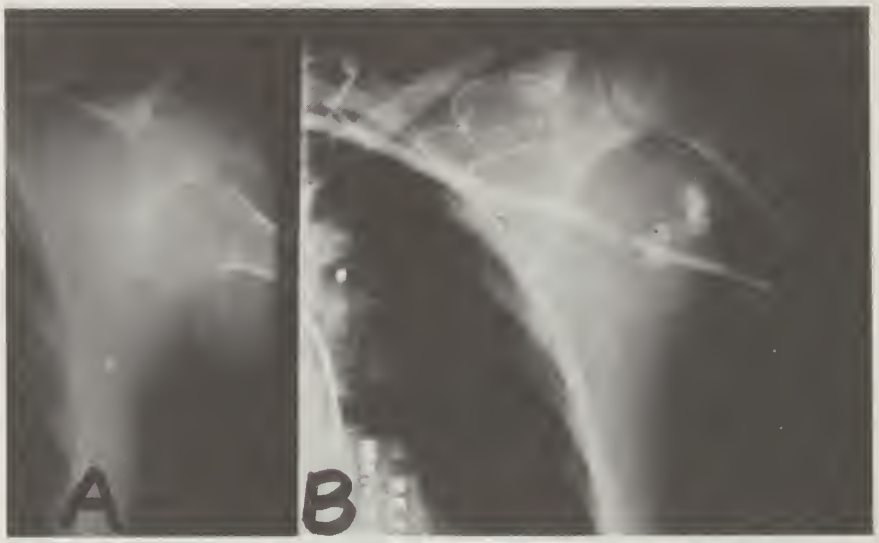


*Figure A.* **Preoperative x-ray shows anterior-inferior dislocation of left shoulder.**
*Figure B.* **Preoperative x-ray shows rupture of third portion of left axillary artery.**

Pulses were present in the other three limbs. X-ray examination of left shoulder revealed anterior-inferior dislocation of the shoulder with a linear fracture of greater tuberosity of the humerus (Fig. A). She had a hemoglobin of 7.4 gm and hematocrit of 21 percent.

By noon the dislocation was reduced. After reduction, the brachial pulse became palpable. Then she was seen on vascular surgical consultation and an urgent arteriography was recommended. This was performed through a percutaneous transfemoral route, and revealed severance of axillary artery in its third portion (Fig. B). M.S. Nalbantian, MD.

She was operated on at 6:00 p.m. that evening. The surgery confirmed rupture of axillary artery and lateral cord of brachial plexus. The arterial ends were plugged with clots which were suctioned out from the proximal end to obtain a good flow. The clot had propogated distally to the palm. Multiple thrombectomy with Fogarty Catheter and irrigation with heparin-saline solution was carried out and the back flow was good.

The arterial wall in this area was minimally arteriosclerotic. After excising the frayed portion of the arterial ends and mobilizing the proximal portion, end-to-end anastomosis with a No. 5-0 Dacron was performed. After the clamps were removed, the pulse returned at the operative site and the wrist. Neurorrhaphy was carried out with a No. 6-0 silk.

The patient's postoperative course was uneventful. She has continued to do well and her pulses have remained strong.

## Conclusion

Absence of pulse at the wrist following shoulder injury indicates proximal occlusion of a major artery, and the need for prompt exploration with a preoperative arteriogram whenever possible. The treatment of choice is primary repair of the artery, and not ligation. □

*Dr. Kia-Noury is attending surgeon at Albert Einstein Medical Center and Frankford Hospital. The report is from the department of surgery at Northeastern Hospital, Philadelphia.*

### REFERENCES

1. **Rowe, C.R.:** Prognosis in dislocations of the shoulder. *J Bone and Joint Surgery 38-A:* 957, 1956.
2. **Stener, B.:** Dislocation of the shoulder complicated by complete rupture of the axillary artery. Successful suture of the artery in an 87-year-old man. *J Bone and Joint Surgery 39-B:* 714, 1957.
3. **DePalma, A.F.:** *Surgery of the Shoulder.* J.B. Lippincott Co., Philadelphia, 1950, p. 214.
4. **Rob, C.G., Standeven, A.:** Closed traumatic lesions of the axillary and brachial arteries. *Lancet 1:* 597, 1956.
5. **Henson, G.F.:** Vascular complications of shoulder injuries. *J Bone and Joint Surgery 38-B:* 528, 1956.
6. **Spek, A. Vander:** Rupture of the axillary artery as a complication of dislocation of the shoulder. *Archives Chirurg Neederlandicum 16:* 113, 1964.

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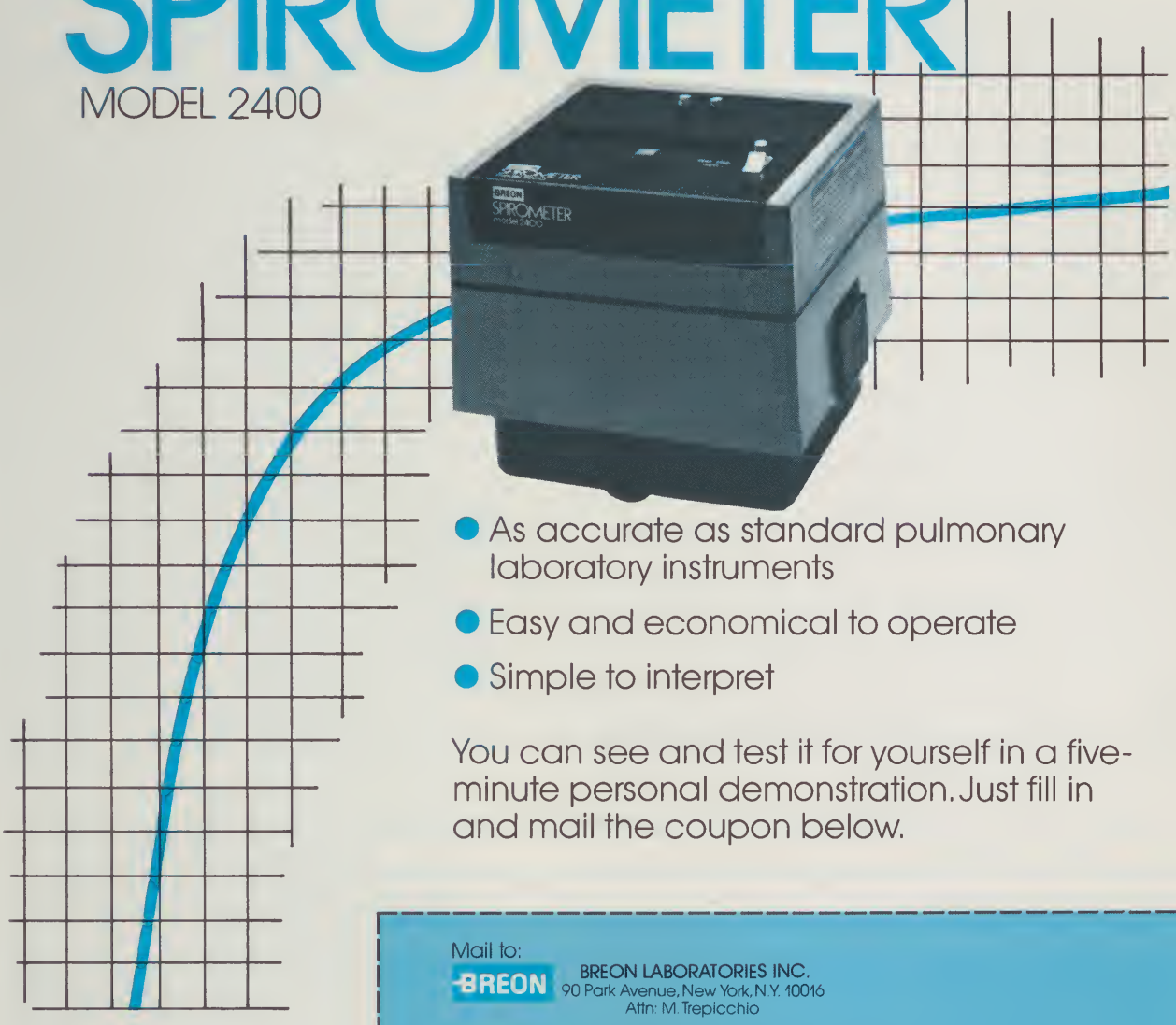


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Results of CME survey

# Primary care physicians make needs known

**Donna S. Queeney, PhD**
**Johny van Nieuwkerk**

In 1978 all Pennsylvania physicians obtaining malpractice insurance were required to earn 150 hours of CME. This regulation, along with a 1972 CME requirement for Pennsylvania Medical Society membership, increased the demand for CME in Pennsylvania. It also led one of the state's major providers of CME to seek ways of expanding physician-oriented CME programs.

The result was a study undertaken by Continuing Education and the College of Medicine at The Milton S. Hershey Medical Center of The Pennsylvania State University, in cooperation with the Pennsylvania Medical Society. The goals of the study were to learn about physicians' preferences with regard to CME programming, and to obtain information on their attitudes toward CME.

## Method

A 32-item questionnaire was used as a mail survey instrument. The questionnaire addressed three major areas: physicians' perceived needs for additional information in 16 areas, their preferences for the delivery of CME, and their attitudes toward mandatory CME.

The target sample was restricted to primary care physicians. Questionnaires were mailed to a random sample of 952 physicians, 254 of whom responded.

## Results

The respondents represented an experienced population, with 60 percent indicating that they were over age 50. Almost 30 percent of those sampled practiced in small towns, another 30 percent had practices in urban areas, 25 percent had suburban practices, and 10 percent were physicians in rural areas.

Ninety-one percent of the respondents belonged to local, state, and national professional associations, and 67 percent belonged to specialty societies. Sixty-four percent were part of a group practice that included two or more physicians.

Less than 25 percent of the respondents were opposed to mandatory CME for any purpose, and at least 50 percent favored it for Pennsylvania Medical Society and specialty society memberships. Eighty-three percent of the respondents indicated that they would maintain their current level of CME participation even if it were not necessary.

In considering the influence that CME has had on their practice of medicine, more than 65 percent of the respondents indicated that it has made some difference in their practice habits. Those who felt that CME had influenced their practice were more inclined to favor mandatory CME than were those physicians who did not believe that CME had a significant effect.

Despite the fact that most of the physicians surveyed felt their practices had been changed by CME participation, more than 75 percent of them also stated that they believed they could keep current professionally without formal CME.

Respondents were asked to rank 13 CME activities according to their usefulness in keeping current. Journal reading was rated the most useful activity. Teaching hospital conferences and textbook reading also were considered beneficial. Most respondents indicated that they found clinical tutorials, correspondence courses, telephone conversations, and mini-residencies rarely useful or that they had not participated in these types of CME activities.

Despite several researchers' recommendations that CME move away from traditional delivery formats, respondents in this study indicated a strong preference for the traditional lecture format. When asked about seven types of program presentations, the physicians indicated that they consider lectures with minimal participation the most effective. Judged least effective were the individual approaches, computer-assisted instruction and audio-visual self-instructional aids.

Respondents were asked to indicate whether they believed they had great, moderate, or hardly any need for current information on each of 16 medical or related topics. In general, they felt they needed information on body systems, but not on practice management. They indicated the greatest needs were for information on the cardiovascular and endocrine systems. Respondents felt the least need for information on research and teaching skills.

Time away from practice was cited most frequently as a major obstacle to participation in CME programs. Twenty-five percent of the respondents indicated a preference for two-hour programs, but 24 percent preferred programs lasting two or three days. Wednesday was the day of the week most frequently preferred for attending one-day CME programs. Saturday and Sunday, followed by late-week days, were the most popular choice for two-day programs.

Fall was the preferred time of year for continuing education activities. Of the physicians surveyed 75 percent were willing to travel no more than 50 miles for a one-day program. The majority were willing to travel 200 miles or more for a program of two or more days.

## Conclusion

This study emphasizes the importance of including physicians in the planning of CME programs; as practitioners they have valuable ideas regarding what information they need and the optimum means of acquiring it. □

---

*The authors are in Continuing Education at The Pennsylvania State University. Copies of the full report are available from Donna S. Queeney, PhD, Planning Studies in Continuing Education, The Pennsylvania State University, 235 Grange Building, University Park, PA 16802.*

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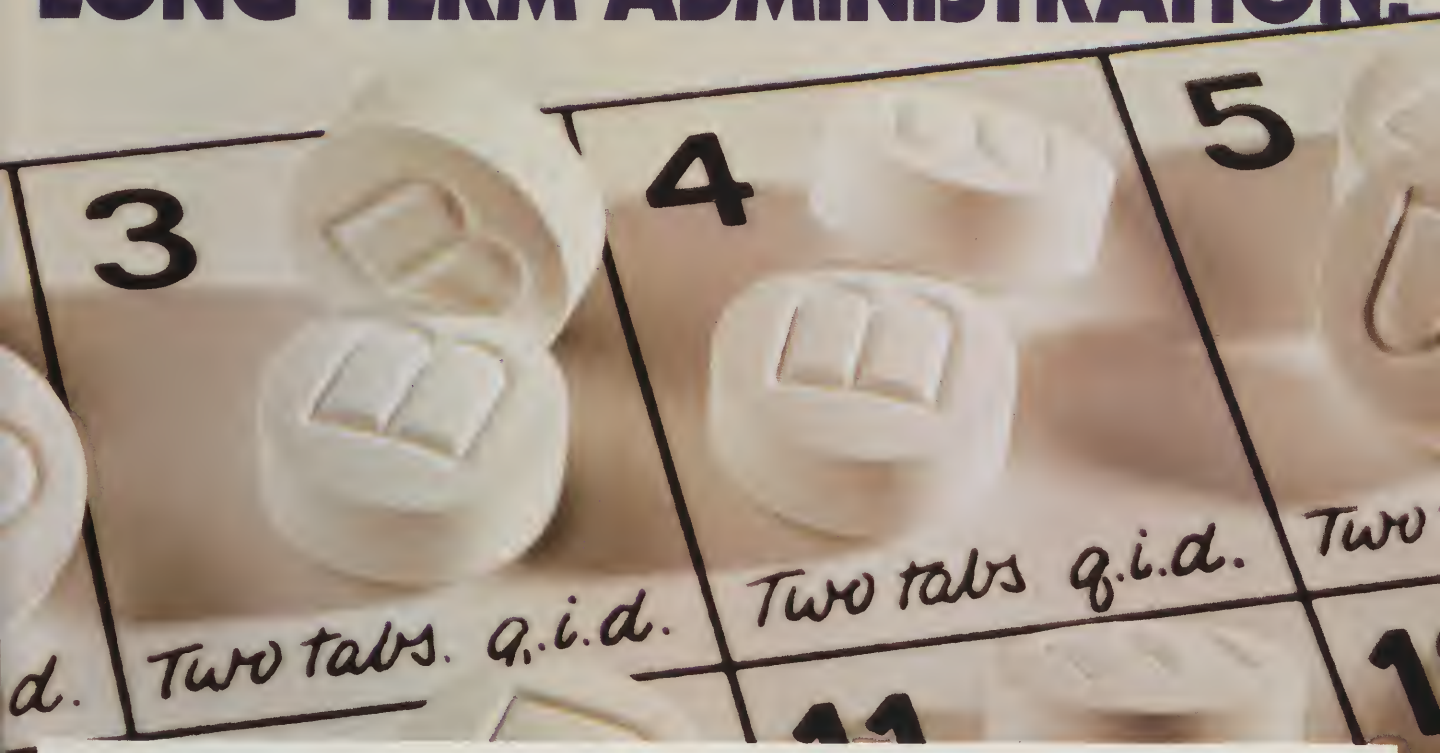

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# Physicians' prescriptions sometimes drug violations

*This update from Drug Law Enforcement, the Bureau of Drug Control reports on six areas in which prescribing physicians are contributing to violations of the drug laws of Pennsylvania. The update results from "Project Discovery," a program which included regulatory inspections of hospitals and reviews of prescriptions.*

The Bureau of Drug Control (BDC) in late 1978 and 1979 inspected all retail and hospital pharmacies in a program called "Project Discovery." As part of these regulatory inspections, prescriptions for controlled substances were reviewed.

Project Discovery has ended and our results indicate that prescribing physicians have contributed to technical violations found in Pennsylvania pharmacies.

**Violations**

We found that some prescribing physicians were not writing the full name and address of the patient on prescriptions for controlled substances.

Some prescribing physicians were not including their DEA number on prescriptions for controlled substances, or had pre-printed DEA numbers on their prescription pads. A physician's DEA number should not be pre-printed on the prescription blank, but handwritten on the prescription at the time the controlled substance is prescribed.

Some prescribing physicians were telephoning in Schedule II controlled substance prescriptions for other than emergency uses.

Prescriptions for Schedule II controlled substances telephoned in an emergency were not covered by a written prescription within 72 hours as required by law.

Some prescribing physicians were allowing physician assistants to use presigned prescriptions blanks to prescribe for patients not seen by the physician.

Some prescribing physicians were writing prescriptions for office use. This is not permitted by federal and state laws. A prescription can be only for a person or animal and a doctor/patient relationship is required. Schedule II controlled substances can be provided by a pharmacy only when a physician submits a DEA-222 form to the pharmacist.

**Forgeries**

Forged prescriptions are increasing in Pennsylvania at an alarming rate. More and stricter security is needed on prescription pads.

Prescribing physicians should not use erasable pens or felt tip pens when writing prescriptions. Ink from erasable pens can be erased up to three days after use depending on the type of paper used in printing the prescription blank and weather conditions. Prescriptions written in felt tip pen can be erased with household bleach.

**Conclusion**

Pennsylvania prescribing physicians should be alerted to these violations and forgeries and should cooperate with the Bureau of Drug Control in these matters. Dispensing physicians in the state should be aware that the inspection program is continuing and audits of dispensing physicians still are being made.


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Case report

# Rocky Mountain Spotted Fever in urban setting

Roger E. Nieman, MD
Richard J. Jones, MD
Albert J. Finestone, MD

Rocky Mountain Spotted Fever (RMSF) is considered infrequently in the differential diagnosis of a febrile illness in a patient, particularly an adult, who recently has not ventured out of an urban setting. In fact, most cases of RMSF occur in rural or suburban areas;[1] cases which do occur in urbanites frequently are related to a recent sojourn to the country.

The low index of suspicion of many urban physicians for RMSF can be dangerous. Only early diagnosis and prompt, specific therapy can ensure a favorable outcome. In recent years, mortality has averaged 5 to 7 percent, but delay in diagnosis and initiation of effective therapy is associated with a higher fatality rate.[2]

We report a confirmed case of RMSF acquired within the city limits of Philadelphia. Our discussion of the early diagnosis of this condition in this isolated case report may alert physicians to consider the diagnosis in similar circumstances.

## Case report

A 57-year-old woman was admitted to Temple University Hospital on June 10, 1979. She had a fever and was confused. Two weeks before admission she manually removed an engorged tick from her right thigh. Five days prior to admission she developed a fever, which rose as high as 104°F. She also noted malaise, photophobia, tinnitus, and headache. Two days prior to admission she visited her physician, who prescribed a penicillin preparation.

She had not left Philadelphia in the weeks prior to her illness, but did note that her Northeast Philadelphia neighborhood was infested with ticks which she frequently removed from her two dogs.

Her temperature on admission was 104.5°F, but the physical examination disclosed no apparent source of the fever. Table 1 lists pertinent laboratory values. A lumbar puncture was within normal limits.

She was treated briefly with ampicillin, gentamicin, and clindamycin. On the second hospital day, a petechial rash appeared on her palms and ankles. We tentatively diagnosed RMSF and changed the therapy to chloramphenicol 50 mg/kg/day.

The rash spread to involve the trunk, where it was at first macular and erythematous, and later petechial and purpuric. The patient responded to chloramphenicol therapy, with resolution of her fever within 48 hours. The antibiotic was continued for a five-day course. The diagnosis of RMSF was confirmed later by fourfold or greater rises in the Weil-Felix agglutinins and complement fixation titers.

TABLE 1

| *Laboratory Test* | *Hospital Day* 1 | 5 | 11 |
|---|---|---|---|
| WBC/mm³ | 4,200 | 12,700 | 6,700 |
| % Polys | 95 | 98 | 71 |
| Platelets/mm³ | 25,000 | 23,000 | 104,000 |
| Prothrombin time (sec) | 11.8 | 15.4 | 12.2* |
| Partial thromboplastin time (sec) | 40.0 | 46.0 | 28.0* |
| Fibrinogen (mg/dl) | ND | 175** | ND |
| Fibrin split products | ND | negative | ND |
| OX-19 | 1:320 | ND | 1:1280 |
| OX-2 | < 1:20 | ND | 1:1280 |
| Complement fixation titer | 1:16 | ND | 1:1024 |

*Day 9
**Normal = 200-400 mg/dl
ND Not Done

## Discussion

Although RMSF acquired its name from the region where it was discovered, it now occurs infrequently in that section of the country. In fact, the 37 cases of RMSF reported in Pennsylvania in 1977, the last year for which figures are available, were more than the combined total of reported cases in all the mountain states for the same year.[3]

Overall, Pennsylvania ranks ninth among states in the number of RMSF cases reported in the last few years,

*The authors are on the faculty in the department of medicine at Temple University School of Medicine, and on the staff at Temple University Hospital, Philadelphia.* *The authors thank Samuel E. Greenspon, MD, who referred the patient.*

with between 30 and 40 cases reported annually.[4]

Most physicians practicing in large cities rarely diagnose a case of RMSF. The increased popularity of camping and suburban sprawl into previously undeveloped areas nevertheless may bring such patients to their office doorsteps.

The difficulties in making this diagnosis are compounded by the fact that many patients do not develop a rash until after several days of illness. In a few patients, a rash may not be noted. Furthermore, serologic studies, even if the results could be known immediately, usually are useful only in making a retrospective diagnosis.

Early diagnosis requires a careful history and physical examination, coupled with a high clinical index of suspicion. Although 58 percent of patients with RMSF give a history of tick bite, for others only a history of exposure to dogs or a wooded area, or often not even that, can be obtained.[1]

Fever, headache, malaise, and myalgias are the symptoms most commonly reported. A rash develops in most patients, usually between the second and sixth days. The rash may be macular and erythematous, petechial, or purpuric. Characteristically it begins on the distal extremities, frequently involving the palms and soles, and spreads to the trunk. A rash involving the plams or soles in an acutely ill febrile patient strongly suggests the diagnosis of RMSF.[5]

Many cases of RMSF are misdiagnosed as cases of measles. Measles usually occurs during the cooler months, when RMSF is rare, and the measles rash begins on the face and then spreads to the trunk and extremities. The rash of atypical measles may more closely mimic that of RMSF, but many patients have an accompanying pneumonitis.[6]

Meningococcemia may be more difficult to exclude clinically. The rash of meningococcemia tends to be distributed randomly over the body, but like RMSF, may begin on the distal extremities. In difficult cases, treatment for both RMSF and meningococcemia may be necessary initially, and chloramphenicol effectively treats both infections.

The WBC count in RMSF usually is elevated mildly, but may be normal or decreased. Thrombocytopenia is not uncommon,[1] and evidence of consumptive coagulopathy may be found.

Serologic confirmation of the diagnosis of RMSF depends on a fourfold or greater rise in Weil-Felix agglutinins or complement fixation titers. An early presumptive diagnosis may be made when the initial OX-2 or OX-19 titer is 1:160 or greater.[7]

It should be stressed that treatment should be started as soon as the diagnosis is suspected, without awaiting serologic confirmation. Early, effective antibiotic therapy may blunt a subsequent rise in either the Weil-Felix or complement fixation titers, making serologic confirmation in such situations difficult.

Finally, neither the Weil-Felix nor the complement fixation test is completely specific for RMSF. In the absence of a clinical illness compatible with RMSF, these serologic studies alone should not be relied upon to secure the diagnosis.

In the experimental animal model of RMSF, rickettsiae may be demonstrated by indirect immune fluorescent stain in a variety of tissues.[8] Gimenez as well as immunofluorescent staining of cultured circulating monocytes from rhesus monkeys infected with *R. rickettsii* also may demonstrate the organisms as early as the fourth day of illness.[9]

Recently, an immunofluorescent technique using guinea pig antisera has been developed for use in human infections, and a diagnosis may be made by examining a skin biopsy specimen stained with the fluorescein-labelled sera.[10] This promising technique is not yet available to most practicing physicians.

Treatment with either chloramphenicol or tetracycline is equally effective. Chloramphenicol may be preferred when other diagnoses, such as meningococcemia or typhoid fever, that can be treated with this drug also are being considered. Antibiotic therapy should be discontinued after the patient has been afebrile for 48 to 72 hours.[7] □

## REFERENCES


1. **Hattwick, M., O'Brien, R., Hanson, B.:** Rocky mountain spotted fever: Epidemiology of an increasing problem. *Ann Intern Med 84:*732-739, 1976.
2. **Hattwick, M., Retailliau, H., O'Brien, R., Slutzker, M., Fontaine, R., Hanson, B.:** Fatal rocky mountain spotted fever. *JAMA 240:*1499-1503, 1978.
3. Center for Disease Control: Annual Summary—1977. *MMWR: 26,* 1978.
4. **D'Angelo, L., Winkler, W., Bregman, D.:** Rocky mountain spotted fever in the United States. *J Infect Dis 138:*273-276, 1978.
5. **Fitzpatrick, T., Arndt, K., Clark, W., Eisen, A., Van Scott, E., Vaughan, J.:** *Dermatology in General Medicine,* McGraw-Hill, Inc., 1971.
6. **Martin, D., Weiner, L., Neiburg, P., Blair, D.:** Atypical measles in adolescents and young adults. *Ann Intern Med 90:*877-881, 1979.
7. **Hoeprich, P.:** *Infectious Diseases,* Second Edition, Harper and Row, Hagerstown, MD, 1977.
8. **Pedersen, C., Bagley, L., Kenyon, R., Sammons, L., Burger, G.:** Demonstration of *Rickettsia rickettsii* in the rhesus monkey by immune fluorescent microscopy. *J Clin Microbiol 2:*121-125, 1975.
9. **DeShazo, R., Boyce, J., Osterman, J., Stephenson, E.:** Early diagnosis of rocky mountain spotted fever; use of primary monocyte culture technique. *JAMA 235:*1353-1355, 1976.
10. **Woodward, T., Pedersen, C., Oster, C., Bagley, L., Romberger, J., Synder, M.:** Prompt confirmation of rocky mountain spotted fever: Identification of rickettsiae in skin tissues. *J Infect Dis 134:*297-301, 1976.

Central Pennsylvania Oncology Group

# Innovative concept in cancer care and research

**Richard H. Dixon, MD**

The Central Pennsylvania Oncology Group is a voluntary professional organization of practicing oncologists, hematologists, radiologists, and oncology nurses. Since 1975, the group has served a 34 county area in Central Pennsylvania.

The professional activities of the group have represented a unique approach to medical research at the community level. The group is a loose conglomerate of practitioners who are following standardized chemotherapy programs for treating patients with malignant disease within their individual hospitals.

Several protocol studies have investigated potentials for improving chemotherapy of malignant disease.

**Adjuvant breast carcinoma**

In one of the earlier studies, this group demonstrated the need for more aggressive chemotherapy and radiation therapy in the postmenopausal patient with breast carcinoma and four or more positive lymph nodes. A multi-agent program of chlorambucil, methotrexate, 5-fluorouracil, and prednisone was superior to single agent therapy with Melphalan in this particular group of patients.

Although Melphalan has been the standard of comparison for other modes of therapy, it is clear that in the postmenopausal age group more innovative and aggressive therapy will be indicated to achieve prolonged survival in the future. As a result of this initial study, the group is undertaking ongoing studies of adjuvant chemotherapy for both premenopausal and postmenopausal patients. Postmenopausal patients now receive Adriamycin and more conventional Cytoxan, methotrexate, and 5-fluorouracil therapy.

Surgery alone is not adequate treatment for many patients with breast cancer. Following radical mastectomy radiation therapy, nearly two-thirds of patients with positive axillary nodes will develop tumor recurrence and eventually die of disseminated disease. As noted above, combination chemotherapy has been shown to be beneficial. These facts have supported the group's studies to improve survival by additional hormonal manipulation.

Previous prospective control studies in prophylactic castration in breast cancer have shown delayed first recurrence, but not prolonged survival. Prophylactic castration generally has been abandoned as a mode of treatment.

To date, no studies of prophylactic castration in a patient population known to have estrogen receptor positive tumors have been reported. The group proposes to study the combined effect of adjuvant chemotherapy, oophorectomy, and anti-estrogen therapy in premenopausal breast cancer patients selected on the basis of estrogen receptor content of the primary.

Since estrogen production in the castrated female may continue, adding an anti-estrogen such as Tamoxifen should insure maximum estrogen deprivation and receptor blockade in these patients. Recent evidence suggests that estrogen receptor status of primary breast cancer correlates with prognosis for disease recurrence and survival. The influence of estrogen receptor status on response to cytotoxic chemotherapy is controversial. Such a study may provide evidence on both of these issues.

**Advanced ovarian carcinoma**

The benefits of Adriamycin and Cis-Platinum combinations in treating ovarian carcinoma were established by this group. In a remarkable study, the patients who previously were treated with alkalating agents and had relapsed with measurable bulk disease were shown to have a fifty percent of second response when retreated with a combination of Adriamycin plus Cis-Platinum and Hexamethylmelamine. Such therapy has altered the course of extensive ovarian carcinoma from one of progressive disease to one in which remissions can be achieved in a large percentage of patients.

From this initial study, two important questions evolved. What did Cytoxan contribute to the effectiveness of this regimen? All the study patients previously had failed to respond on another alkalating agent. Second, why did patients who received radiotherapy or who had far advanced disease experience considerable myelo-suppression during the previous study?

Our current protocol compares two regimens, each consisting of three of the four active drugs in the above protocol in the attempt to answer these questions. Through this study, a simpler, less toxic but effective program for the treatment of advanced ovarian carcinoma may evolve.

**Small cell carcinoma**

The effectiveness of multi-agent chemotherapy for small cell carcinoma of the lung was established using multiple drugs in combination. Several years ago, our group treated 150 patients with various combinations of chemotherapy and the patterns of disease response and relapse were studied. From these studies the

*Dr. Dixon is on the staff of Centre Community Hospital, State College, Pennsylvania.*

incidence of local recurrence was found to be relatively high and the need for further increased radiation therapy within the local area was emphasized.

Secondly, a need was established for prophylactic whole brain radiation in patients with disseminated small cell carcinoma of the lung in an effort to prevent central nervous system metastases. Although the overall potential responsiveness of this neoplasm to multi-agent chemotherapy was emphasized, several other questions were raised by this study.

Can partial responders to induction chemotherapy be converted to complete responders by adding further radiotherapy and changing the drug program? Can addition of another active drug, an investigational agent, VP16-213 (4′-demethylepipodophyllotoxin-3-D-ethylidene glucoside) lead to increased survival and improved quality of survival in patients with small cell anoplastic carcinoma of the lung?

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Reading Hospital, Reading
Centre Community Hospital, State College
Williamsport Hospital, Williamsport
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### Melanoma immunotherapy

Recently, the efficacy of immunotherapy with BCG in treating early melanoma has been emphasized. Our ongoing studies are comparing the effects of BCG with another immunoadjuvant, C-parvum. To date these studies confirm the usefulness of immunotherapy with BCG in patients with early malignant melanoma.

In Stage II patients, (regional lymph node metastases) from malignant melanoma, a significant survival and disease free interval was documented when immunotherapy with Corynebacterium parvum was used. Five of fourteen patients receiving C-parvum relapsed; nine of thirteen patients receiving BCG relapsed during the course of this study. This study emphasizes the potential effectiveness of immunotherapy in attempts to prevent early recurrence in patients with non-disseminated malignant melanoma.

### New approaches to therapy

Several innovative approaches are being investigated by our group. These include antiplatelet therapy to inhibit metastatic disease in previously refractory neoplasms such as bronchogenic carcinoma and adenocarcinoma of the colon. Intensive studies of various hormone effects of antiestrogen compounds, Tamoxifen and Aminoglutothamide are ongoing.

The group has received recognition from the National Cancer Institute which has made Phase II drugs available for our investigations. These include VP16 for oat cell carcinoma and Dibromodulcitol for the therapy of metastatic malignant melanoma.

As a result of these studies, our group has sponsored several publications. The net result of these studies has shown that treatment of malignant disease can be as successful in the community hospital as in the large medical centers or the multi-center chemotherapy groups.

### Cancer control

In addition to chemotherapy protocols, the group has been active in cancer control. The group currently is supported by the House of Representatives under a bill sponsored by Representative Kenneth Cole of Gettysburg.

In our current projects we are studying the economic impact of cancer on patient and family, and the effect of nutritional guidance on the prognosis of malignant disease. We have established a clergy residency program at Hershey Medical Center, and we have compiled cancer services for the entire 24 county area for handy reference for patients and professionals dealing with malignant disease.

Approximately 46 nurses have completed a course in cancer screening and detection. The course included intensive practical experience at the Geisinger Medical Center. These nurses now in the field are examining patients in public health and industrial settings, and physicians' offices in an effort to improve our cancer screening and early detection.

With the National Cancer Institute's increasing interest in funding regional therapy programs, the Central Pennsylvania Oncology Group will continue to expand its resources and to provide a wide spectrum of care for patients in Central Pennsylvania.

*A NOTE OF SPECIAL APPRECIATION....*

*...To those doctors who have been so courteous and helpful in Northwestern Pennsylvania.*

*Your consideration toward Inter-County Health Plan's efforts to become established in the St. Marys and Meadville areas will be mutually beneficial as Inter-County becomes a leading provider of group accident and sickness insurance in this part of our State.*

*Inter-County brings to you the solid experience and dedication of its trained staff; experience gained by our affiliate, Inter-County Hospitalization Plan, which has provided more than 40 years of service to hospitals and doctors in the Philadelphia and Lancaster areas.*

*Inter-County is the ONLY not-for-profit health insurer in Pennsylvania that pays both doctor and hospital bills with one staff, from one location. This combination of services effectively eliminates the major cause of delayed payment to you, the transferring of claim information from one insurer to another.*

*If you have not yet heard of Inter-County or if you would like further information regarding participation, please call Inter-County toll-free at our executive offices in Jenkintown, Pennsylvania, (800) 492-2385 or write to:*

*Inter-County Health Plan, Inc.*

*ATTN: Professional Relations Department*

*Foxcroft Square*

*Jenkintown, Pennsylvania 19046*

*"Serving Pennsylvanians for Over 40 Years"*

# New debt collection regulations govern physicians

The Bureau of Consumer Protection of the Pennsylvania Department of Justice has promulgated new regulations dealing with debt collection trade practices. The entire regulation should be read by any physician who engages in debt collection or has a debt collection agency do such work.

Some specific regulations that need to be called to physicians' attention are listed below.

**§ 303.3. General provisions**

While engaged in the collection of debts, it shall be an unfair or deceptive act or practice for a creditor or debt collector to engage in any of the following acts or practices: . . .

(24) Visiting a person, causing a telephone to ring, or engaging any person in telephone conversation at any unusual time or place or a time or place known or which should be known to be inconvenient to the person called or visited. For the purpose of this paragraph, in the absence of knowledge to the contrary, a convenient time shall be between 8 a.m. and 9 p.m.

(25) With regard to communications with third parties:

(i) Without the written consent of the debtor given directly to the creditor or debt collector subsequent to the commencement of collection activities or without the express permission of a court of competent jurisdiction or as reasonably necessary to effectuate a post-judgment judicial remedy, communicating, threatening to communicate or implying the fact of a debt to any person other than the debtor in any manner.

(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, while otherwise in conformity with this chapter, communications regarding the debt shall be permitted to the following:

(A) a consumer reporting agency as defined by section 603(f) of the Consumer Credit Protection Act (15 U.S.C. § 1681a(f), if otherwise permitted by law;

(B) the attorney of the creditor, debt collector, or debtor;

(C) other persons who the creditor or debt collector reasonably believes has extended or will extend credit to the debtor;

(D) debt collector, if the creditor is the communicator;

(E) creditor, if the debt collector is the communicator;

(F) seller of the goods or services which are now in whole or in part the subject of the debt;

(G) any prior holder of the instrument evidencing the debt;

(H) a prospective purchaser of the debt; or

(I) any other party expressly authorized by law.

(iii) Notwithstanding the provisions of subparagraph (i) of this paragraph, while otherwise in conformity with this chapter and unless expressly prohibited by the debtor, a creditor or debt collector shall be permitted one communication to a nondebtor spouse regarding the debt; provided, however, that the spouse of the debtor may expressly authorize additional communications.

(26) Abusing or harassing the debtor, directly or indirectly, through third party contacts.

(27) Otherwise abusing or harassing any person in connection with the collection of a debt.

(28) Obtaining or attempting to obtain any waiver of the requirements of this chapter from any person by contract or otherwise.

**§ 303.4. Communications and contacts with the debtor**

While engaged in the collection of debts, it shall be an unfair or deceptive act or practice for a creditor or debt collector to engage in any of the following acts or practices:

(1) Communicating with or contacting the debtor without initially disclosing the identity of the caller, including the name of the person calling, the company or firm represented, the name of the creditor if a different company or firm, and any other information necessary to identify the caller. For the purposes of this section, when contacting a third party during an attempt to communicate with the debtor, the caller shall disclose the caller's name and, only if expressly requested, the name of the caller's employer.

(2) Abusing or harassing the debtor by telephone. For the purposes of this section, a rebuttable presumption of abuse or harassment shall be created if a creditor or debt collector continues to telephone the debtor during any seven-day period following a telephone discussion between the creditor or debt collector and the debtor. Evidence of reasonable followup activity may be sufficient to rebut the presumption of abuse or harassment. However, in no event shall the creditor or debt collector place telephone calls to the debtor at the debtor's place of employment, which is not the current billing address of the account, unless:

(i) the creditor or debt collector has been unable to effect a discussion regarding the debt with the debtor during the preceding 30-day period by telephone calls or personal visits; and

(ii) the creditor or debt collector does not know or has no reason to know that the debtor's employer prohibits such contacts.

(3) Placing telephone calls to the debtor at the debtor's place of employment after the debtor has notified the creditor or debt collector in writing not to place such calls.

(4) Abusing or harassing the debtor by household visits. For the purposes of this paragraph, a rebuttable presumption of abuse or harassment shall be created if the creditor or debt collector continues to visit the household of the debtor during any 30-day period following a visit which resulted in a discussion between the creditor or debt collector and the debtor. Evidence of reasonable followup activity may be sufficient to rebut the presumption of abuse or harassment.

(5) Entering the houshold of a debtor unless expressly invited inside by the debtor or any adult person in the household of the debtor.

(6) Failing to leave the debtor's premises when asked to do so by the debtor or any person in the household of the debtor.

(7) Mailing communications to the debtor at the debtor's place of employment, unless the current billing address of the account is the debtor's place of employment or unless the

debtor specifically consents to such communications in writing subsequent to the commencement of collection activities.

(8) Visiting the debtor at the debtor's place of employment, unless in response to a written request from the debtor.

(9) If a communication could reasonably be expected to be overheard by any third party not authorized by the debtor, confronting any debtor at the creditor's or debt collector's place of business, at places agreed to by the debtor, or at any public place.

(10) Except as provided in section 303.3(25) of this title (relating to general provisions), communicating with or contacting any person other than the debtor's attorney, if the creditor or debt collector knows or has reason to know that the debtor is represented by an attorney with respect to such debt, and has knowledge of or can readily ascertain the address of the attorney, unless:

(i) the attorney fails to respond within a reasonable period of time to a communication from the creditor or debt collector. For the purposes of this subparagraph, 14 calendar days shall be considered a reasonable time;

(ii) the attorney authorizes direct contact or communication with the person;

(iii) contact is necessary to perfect or preserve rights against the debtor or collateral securing the debt; or

(iv) direct contact with the debtor is required by an applicable State or Federal law, regulation or court order.

(11) If a debtor notifies a debt collector in writing that the debtor refuses to pay a debt or that the debtor wishes the debt collector to cease further communication or contact with the debtor, the debt collector shall not communicate with or further contact the debtor with respect to such debt, except:

(i) to advise the debtor that the debt collector's further efforts are being terminated;

(ii) to notify the debtor that the debt collector or creditor may invoke specified remedies which are ordinarily invoked by such debt collector or creditor; or

(iii) where applicable, to notify the debtor that the debt collector or creditor intends to invoke a specified remedy.

**§ 303.7. Disputed debts**

While engaged in the collection of debts, it shall be an unfair or deceptive act or practice for the creditor or debt collector to engage in any of the following practices:

(1) Failing to suspend collection activities until the creditor or debt collector has investigated and responded to any written allegation of the debtor that the amount owed is not owed, is inaccurate or is otherwise in error; provided, however, there shall be no obligation to respond to duplicative requests.

(2) Failing to suspend collection activities until the creditor or debt collector has responded to any written request from the debtor for copies of materials which substantiate the debt; provided, however, there shall be no obligation to respond to duplicative requests.


Institute for Medical Education and Research
Geisinger Medical Center
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As an organization accredited for continuing medical education, Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. (Refer to each program: full day, 7 hours credit; half day, 4 hours credit.)
**For further information write to Millie K. Fleetwood, Ph.D., Geisinger Medical Center, Danville, PA 17821 or telephone (717) 275-6925.**

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If you haven't, then you are not taking advantage of all the benefits being offered through the Pennsylvania Medical Society.

This new option will enable your group insurance to continue **after retirement!**

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**1.** Solo corporations and up may enroll

**2.** Premiums are **tax-deductible.**

**3.** $100,000 coverage available on physicians without medical exam.

**4.** Accidental death and dismemberment and premium waiver are included.

**5.** Guarantee Issue Amounts Available:

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| Firms with | 0 - 4 lives | $10,000 |
| | 5 - 9 lives | 20,000 |
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| | 15 and over — | 50,000 |

**6. Dividends** — 20% returned to participating corporations the past three years.

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**1.** This option continues your group insurance **after retirement.**

**2.** No medicals are required up to age 65

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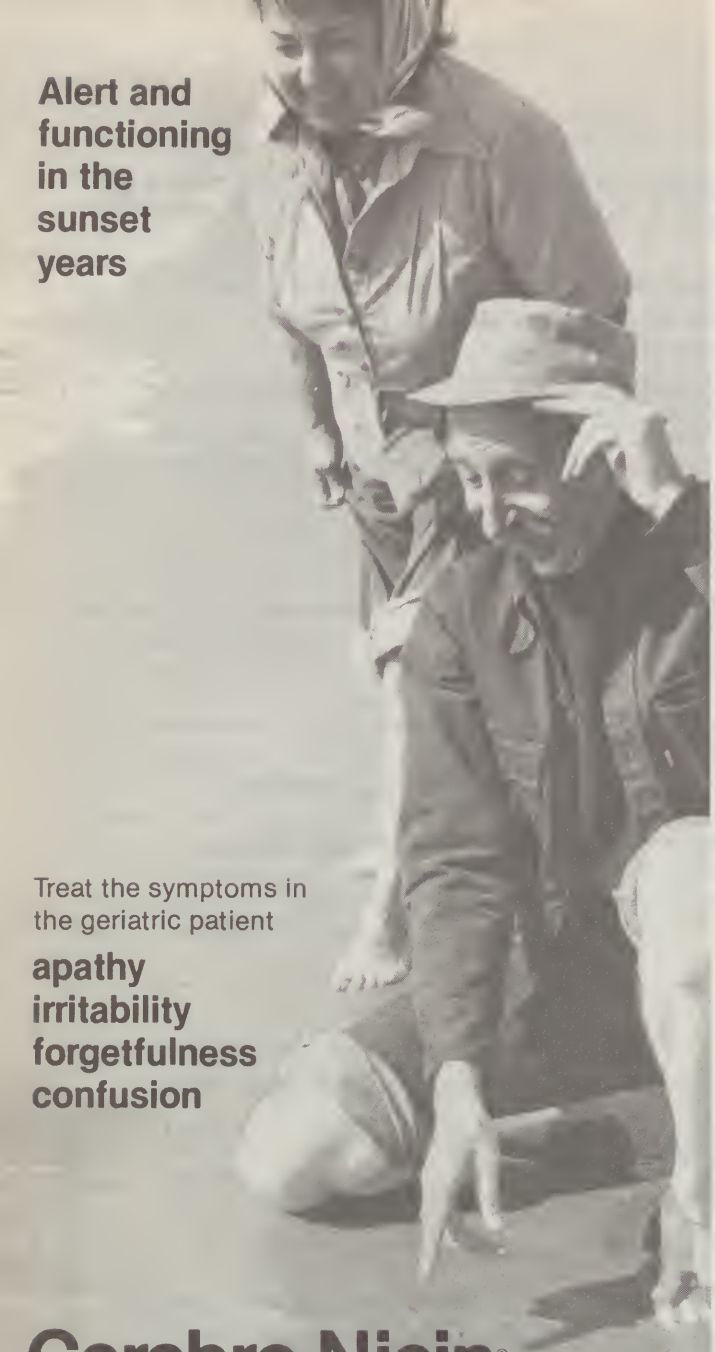

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Vincent M. Balestrino, MD, Family Practice, St. Margaret Mem. Hosp., Pittsburgh 15201
Samuel O. Bricker, MD, Family Practice, 830 Jancey St., Apt. 2, Pittsburgh 15206
William C. Dundore, Jr., MD, Obstetrics Gynecology, West Penn Hosp., Pittsburgh 15224
Garry L. Fuller, MD, Anesthesiology, 105 Bentley Dr. Pittsburgh 15238
George M. Gavin, MD, Family Practice, 416 A Glen Malcolm Dr., Glenshaw 15116
Gary R. Holdin, MD, Emergency Medicine, 400 Jefferson Ave., Washington 15301
Ryon Huh, MD, Physical Medicine & Rehabilitation, 1728 Fox Chapel Rd., Pittsburgh 15238
Raj G. Kansal, MD, Urology, 45 Crosswinds Dr., Pittsburgh 15220
Rajeshwar D. Kapoor, MD, Internal Medicine, 307B Glen Douglas, Glenshaw 15116
Behrooz Khalili, MD, Obstetrics/Gynecology, Pride & Locust Sts., Pittsburgh 15219
William A. Kramer, MD, Family Practice, St. Margaret Mem. Hosp., Pittsburgh 15201
Dennis M. Krivinko, MD, Obstetrics/Gynecology, 227 Union Ave N Versailles 15137
Ruth L. Lasell, MD, Psychiatry, 3811 O'Hara St., Pittsburgh 15261
James L. Latimer, MD, Family Practice, St. Margaret Mem. Hosp., Pittsburgh 15201
Steven L. Lempert, MD, Ophthalmology, 1420 Centre Ave., Pittsburgh 15219
Joseph R. Love, MD, Family Practice, 11676 Perry Hwy Prof. Bldg., Wexford 15090
John D. Mackie, DO, Family Practice, 220 Meyran Ave., Pittsburgh 15213
Patricia L. Maclay, MD, Internal Medicine, 2293 Beechwood Blvd., Pittsburgh 15217
Thomas D. McCoy, MD, Obstetrics/Gynecology, West Penn Hosp., Pittsburgh 15224
Thaddeus A. Osial, Jr., MD, Internal Medicine, 985 Scaife Hall, Pittsburgh 15213
Marc B. Pomerantz, MD, Internal Medicine, 320 E. North Ave., Pittsburgh 15212
Oscar M. Reinmuth, MD, Neurology, 322 Scaife Hall, Dept. N, Pittsburgh 15261
Ted C. Schaffer, MD, Family Practice, 100 Primrose Ave., Glenshaw 15116
Diane P. Shank, MD, Family Practice, 265 46th St., Pittsburgh 15201
Gregory N. Smith, MD, Family Practice, SMMH 265 46th St., Pittsburgh 15201
Yehunda M. Traub, MD, Internal Medicine, 3018 Beechwood Blvd., Pittsburgh 15217
Luzviminda N. Turalba, MD, Family Practice, 14555 Ridge Rd., N. Huntingdon 15642
Kenneth K. Ung, MD, St. Margaret Mem. Hosp., Pittsburgh 15201
Alan S. Unis, MD, Psychiatry, 3811 O'Hara St., Pittsburgh 15261
Paul L. Weiner, MD, Radiology, 9102 Babcock Blvd., Pittsburgh 15237

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Jasmat N. Kansagra, MD, Anesthesiology, 1086 Franklin St., Johnstown 15905

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Seung Chan Lee, MD, Anesthesiology, RD #9, Kennedy Hill, Meadville 16335
James G. Salerno, MD, Obstetrics/Gynecology, 505 Poplar St., Meadville 16335

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Frederick A. Hensley, MD, Anesthesiology, Apt. 88, Univ. Manor, Hershey, 17033
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Vincent D. Larkin, Jr., MD, General Surgery, Ste. 207, Med. Arts Bldg., Scranton 18503
William S. Peters, DO, Family Practice, 216 N. Sumner Ave., Scranton 18504
Madhava S. Rao, MD, Internal Medicine, 220 Linden St., Scranton 18503

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Houshang G. Hamadani, MD, Psychiatry, 3012 Devonshire Rd., Allentown 18103
Philip B. Metzger, MD, Colon & Rectal Surgery, P.O. Box 83, Macungie 18062
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Lee T. Besen, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
John J. Bobeck, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
John L. Carey, MD, Internal Medicine, Narrows Mall Office Bldg., Edwardsville 18704
Anthony Colangelo, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
Robert Czwalina, DO, Family Practice, RD #3, Beverly Dr., Wyoming 18644
Dennis J. Kepka, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
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Maureen R. Maguire, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
Clyde P. Mitchell, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
Felix L. Oliver, MD, Radiology, 25 Brooklane, Mountaintop 18707
Deborah A. Pincofsky, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
Francis J. Schell, MD, Family Practice, 534 Wyoming Ave., Kingston 18704
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Neil L. Isdaner, MD, Obstetrics/Gynecology, 282 Birch Dr., Lafayette Hill 19444

**TIOGA COUNTY:**
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**UNION COUNTY:**
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**WARREN COUNTY:**
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Robert J. Weiss, MD, Ophthalmology, 104 St. Clair St., Warren 16365

**WESTMORELAND COUNTY:**
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**YORK COUNTY:**
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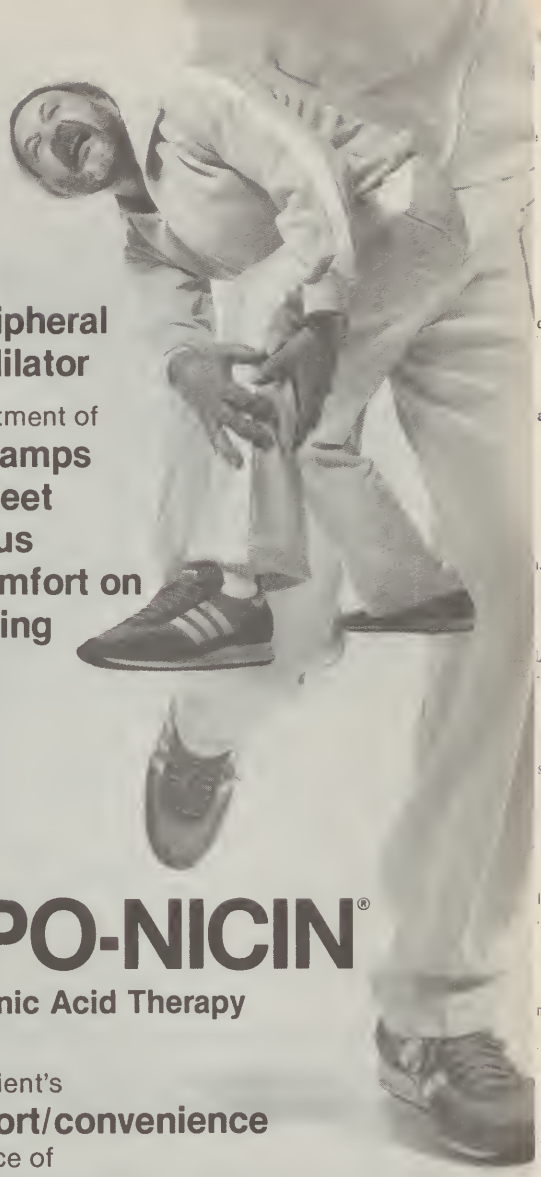
John J. Bobin, MD, 505 Madison Ave., York 17404
David L. Cohen, MD, Orthopedic Surgery, 1930 Security Dr., York 17402
John H. Ellis, IV, MD, 1927 Queenswood Dr. J 103, York 17403
Detlef H. Gerlach, MD, Obstetrics/Gynecology, 1601 S. Queen St., York 17403
John P. Manzella, MD, Internal Medicine, York Hospital, York 17402

**Correction to new members listing in February, 1980 issue**
**Alan M. Resnik, MD, Colon and Rectal Surgery, 1427 Spruce Street, Philadelphia 19102**
Note that since the listing Dr. Resnick has relocated his office.
**John L. Rombeau, MD, Colon and Rectal Surgery, Univ. of Pa. Hosp., Philadelphia 19104**

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**AVAILABLE:** Bottles of 100, 500.

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Each blue tablet contains:
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Riboflavin (B-2) . . . . . 2 mg.
Pyridoxine HCL (B-6) . . . . . 10 mg.
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**Indications:** For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

**Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

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3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically
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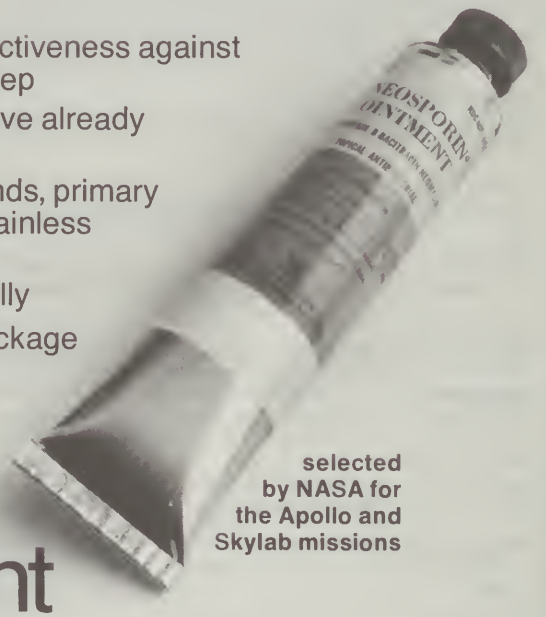

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(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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North Carolina 27709

# classifieds

## PHYSICIANS WANTED

**Full-time house physician** — position offers competitive salary and fringe benefit package. A Pennsylvania license is required; also DEA number. Contact: Jay H. Davidson, MD, Chief of Medicine, (215) 787-2175 or write to: James C. Giuffre Medical Center, 8th St. and Girard Avenue, Philadelphia, PA 19122. Equal Opportunity Employer.

**Good opportunity G.P./F.P.** — for growing area near university, tremendous potential and urgent need. Private practice in central western Pennsylvania. Will sponsor and guarantee. Dr. S.W. Greenwald, 290 Grant St., Indiana, PA 15701, phone (412) 463-0508 or 479-2800.

**Obstetrician-Gynecologist** — Indiana, Pennsylvania — A beautiful university community located 60 miles north and east of Pittsburgh, PA. Indiana Hospital is a 200-bed general hospital, completing a $22 million building and renovation program, which will provide the finest in medical facilities and equipment. It is the only general hospital in Indiana County, serving a population of over 80,000. The potential for a medical practice in obstetrics and gynecology is excellent due to a strong expanding economy and a young family growth in this area which has generated the need for additional physicians in this specialty. The area has an excellent school system, fine recreational facilities with lakes, streams, and mountain terrain for the various sports. The practice opportunity is open either for a private practice or in a partnership. Inquiries should be directed to either Richard N. Freda, MD, The Ben Franklin Medical Center, Shelley Dr., Indiana, PA 15701 (412) 463-0225 or Donald F. Smith, President, Indiana Hospital, Indiana, PA 15701 (412) 357-7120.

**Emergency physician** — to join congenial six man group. Northwestern Pennsylvania 600 bed general hospital; 50,000 annual ED visits. Training in either Emergency Medicine or Surgery. Leadership or administrative experience desirable. Clean metropolitan community of 265,000; five area colleges; many cultural and recreational opportunities; year round outdoor activities. Join professional corporation after one year; 80K; fringes. Send C.V. to Department 840, Pennsylvania Medicine, 20 Erford Road, Lemoyne, PA 17043.

**Pennsylvania** — Emergency physician system. Needs several fulltime emergency physicians for Western Pennsylvania area emergency departments. Independent contractor arrangements. Eligible for corporate membership within two years. The system is on a "fee-for-service" basis. Contact: (412) 228-3400 for interview appointment.

**Camp physicians needed** — Camp Chen-A-Wanda, fine Pennsylvania Co-ed camp, season begins June 28, ends August 23. Physicians accepted for two weeks to four weeks. Excellent living accommodations for physician and family. Write: Mr. and Mrs. Morey Baldwin, 8 Claverton Court, Dix Hills, NY 11747. Call collect (516) 643-5878 (evenings).

**Career opportunities** — Throughout Pennsylvania and from coast-to-coast for physicians in all specialties. All Fees assumed by employers. Send CV with objectives to Medical Recruitment Division, Dr. Personnel of Pittsburgh, Inc., (31 offices nationwide), 121 University Place, Pittsburgh, PA 15213, (412) 621-9975.

**Pediatrician and other physicians wanted** — for Bethel Park, Pennsylvania, suburb of Pittsburgh, 35,000 people. New professional building. Call (412) 833-6188.

**General surgeon** — North Carolina. Needed for University owned hospital in small coastal town. This private practice opportunity is ideal for an experienced general surgeon who would enjoy a relaxed, productive life style in a desirable climate on the coast. Send CV to Department 839, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

**Ophthalmologist** — Retinal specialist to associate with busy general ophthalmologist in Philadelphia. This might be a part-time association. Please send curriculum vitae in reply to Department 838, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

**Emergency room physician** — Immediate opening for full time emergency room physician. Salary and fringe benefits are competitive. Send resume to Mr. Richard A. Anderson, Administrator, Canonsburg General Hospital, Barr Street, Canonsburg, PA 15317.

**Psychiatrists and physicians** — Board certified or Board eligible Pennsylvania Licensure required. Immediate openings. Excellent opportunity to work in developing new programs in a state hospital. Salary competitive. Limited housing available. Excellent fringe benefits. 40 miles east of Pittsburgh. Call (412) 459-8000 or write to Ray Bullard, MD, Superintendent, Torrance State Hospital, Torrance, PA 15779. An Equal Opportunity Employer.

**Emergency medicine opportunities available** — Opportunities available to assume clinical and directorship responsibilities in several emergency departments located in western Pennsylvania. Excellent income, flexible scheduling, and paid professional liability insurance. Part-time opportunities also available. For details, send credentials in confidence to Mr. James Thomas, 230 Park Avenue, Suite 303, New York, New York 10017, or call collect (212) 599-0060.

**Family practitioner** — Tampa Bay Area, Florida. Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., Attn: Jerry Williamson, MD, 1417 South Belcher Road, Clearwater, Florida 33516; (813) 535-3474.

**Internist** — Tampa Bay Area, Florida. Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, MD, Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516; (813) 535-3474.

**Resident physician** — and resident nurse wanted for well-established children's sleepaway camp, Wayne County, Pennsylvania. Two and four weeks available in July. 2 RNs on duty. Families accommodated and are welcome to participate in all activities. Call (516) 466-8698 collect evenings.

**Pennsylvania Emergency Physician** — 200-bed general hospital located in western Pennsylvania university community. New modern Emergency Department. Salary highly competitive. PA license required. Contact: William B. Yeagley, MD, Director of Department of Emergency Services, Indiana Hospital, Indiana, PA 15701.

**Pediatrician wanted** — provide pediatric services at Silver Springs, Martin Luther school, a residential treatment facility for emotionally disturbed children. Requires approximately 4-5 hours every two weeks doing annual physicals, routine medical needs, and availability for phone consultations. Prefer affiliation with Chestnut Hill, Montgomery, or Sacred Heart Hospital. Contact Robert F. Bartelt, Silver Springs, Martin Luther School, Township Line Road, Plymouth Meeting, PA 19462.

**NEEMA Emergency Medical** — a professional association — Emergency medicine positions available with emergency physician groups throughout Pennsylvania, New York, New Jersey, Michigan, and Southeastern U.S., including all suburban, rural, and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to NEEMA Emergency Medical, Suite 400, 399 Market St., Philadelphia, PA 19106. In PA call (215) 925-3511, those outside of PA call 1-800-523-0776.

**House Staff Physician** — Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $40,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Executive Director, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

**Orthopedic Surgeon Wanted**—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Medical director** — Allied Services, located at the foothills of the scenic Pocono Mountains, is the largest comprehensive-care rehabilitation facility in the eastern United States. Allied is currently seeking a board certified physiatrist for the position of medical director, who will be responsible for the overall medical services of the accredited 90-bed Institute of Rehabilitation Medicine, and supervise a full-time physiatry staff. The position offers tremendous opportunity, salary, and fringe benefits. For more information, call collect (717) 348-1343, Michael J. Aronica, MD, Allied Services, 475 Morgan Highway, Scranton, PA 18508.

**Emergency physicians** — Philadelphia and suburban Philadelphia hospitals. Fee for service with minimum guarantee, 42 hr. per week avg. Experience preferred but will consider all applicants. Contact Teddy Trout (215) 438-0390 for further details or send CV to EMSS, 5555 Wissahickon Ave., Suite L6, Philadelphia, PA 19144.

**Directorship and staff** — applications are now being accepted for full-time and part-time, Emergency Department and In-Hospital positions. Attractive opportunities are now available with reputable hospitals in economically sound areas of Ohio and peripheral states. Forward your C.V. and references to Doctors Services, Inc., Executive Commons East, Suite 313, 29525 Chagrin Blvd., Cleveland, Ohio 44122.

**Psychiatrist** — board-certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact George E. Gittens, MD, Acting Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411, (717) 586-2011.

**Anesthesiologist** — Associate, licensed in Pennsylvania. Board eligible or certified. 212-bed general hospital in western Pennsylvania. Extremely active surgical service. Competitive compensation plus comprehensive benefit program, including liability insurance, educational leave, etc. Mail resume to Mr. Robert L. Engel, Administrator, Armstrong County Memorial Hospital, Kittanning, PA 16201.

**Post Residency Fellowship** — in geriatric psychiatry for psychiatrists or primary care physicians. NIMH sponsored training program emphasizes interdisciplinary, comprehensive care of ambulatory patients, geriatric medicine and social gerontology as well as geriatric psychiatry. Opportunities in inpatient and outpatient care, community liaison and research. Contact Monica D. Blumenthal, MD, PhD, Geriatric Psychiatry Program, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15261.

**Physicians** — Excellent opportunities exist throughout the nation. Hospitals, clinics, solo practices, etc., in a broad range of specializations. Send us your curriculum vitae and we will compare your objectives with our assignments. We can confidentially and successfully complete your search. Doctors Services, Inc., 29525 Chagrin Blvd., Suite #313, Cleveland, OH 44122.

**Emergency Room Physician** — Six year old, 212 bed community hospital, Western Pennsylvania. Full-time position available. Physician participates in all hospital benefit programs including liability insurance. In addition to 3 weeks paid vacation, an additional 5 days is made available for continuing education in Emergency Medicine each year. Write or call: F.O. Robertson, MD, Director, Emergency Medical Services, Armstrong County Memorial Hospital, Kittanning, PA 16201. (412) 543-8404 Collect.

**Physicians** — for clients in Pennsylvania, Massachusetts, and Ohio. Specialists in FP, PD, radiotherapy, ENT, psychiatry, physical medicine, and a director Ob-Gyn. Please call E. J. Mowry, (215) 348-8700.

**Unique opportunity** — for practice of family medicine, pediatrics, or internal medicine in Southeastern Pennsylvania. Attractive new office space. Write Department 837, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Physician placement by physicians** — unique hospital, group, and solo opportunities available in all specialties throughout Pennsylvania and coast-to-coast. Urban, suburban, and rural openings. Forward C.V. with your objectives in confidence to M.C. Staschak, MD, & Associates, 5th Floor - M, Manor Building, Pittsburgh, PA 15219, (412) 765-3555 (answers 24 hours).

## FOR RENT

**Prime Philadelphia location for medical/lab space** — Newly renovated 3½ story professional building opposite new Wills Eye and ½ block from Jefferson. Fully A/C, gas heat, automatic elevator. Adequate parking and trans. Aprox. 5,000 sq. ft. available for rent. Call (215) 887-5585, James D. Scully Co.

## FOR SALE

**Elegant office** — home combination in Cornwall, Pa., near 4 hospitals. 4 bdrms, custom kit., 2 fireplaces, 900 sq. ft. office with off street lighted parking. Owner financing possible, $159,000. (717) 272-5713.

**For sale, rent, or will share office** — approximately 1,500 sq. ft. Prominent location, fully equipped. Continual medical office for last 75-80 years. Building has income to support it, 1st floor all office, 2nd & 3rd floors rental property (rented). Call or write: H.A. Coyer, MD, 1501 N. Second St., Harrisburg, PA 17102, (717) 234-4834 or (717) 774-7174.

### CONTINUING EDUCATION

**Sixth Annual Family Medicine Review Course** — June 1-6, 1980 Annapolis, Maryland. Sponsored by the University of Maryland School of Medicine. Information contact: Program of Continuing Education, 10 S. Pine Street, Baltimore, Maryland 21201 or (301) 528-3956.

**Genetics in Clinical Oncology** — September 22, 23, New York City. Offered by Genetics Laboratory, Pathology Department, Memorial Hospital for Cancer and Allied Diseases. Topics: Chromosome changes in leukemia, tumors; hereditary predisposition to cancer; etiology and nature of cancer; genetic counseling, indications for genetic cytogenetic work-up. Approved for 15 credit hours AMA Category I. Fee: $200. Co-directors: R.S.K. Chaganti, PhD, James L. German, III, MD. For information, write: Dr. R.S.K. Chaganti, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021; (212) 794-7100.

### MISCELLANEOUS

**Financial Planning-Tax Havens** — Reduce personal tax liability. Increase net worth. Improve profitability of your private, group, or corporate practice. Reduce, defer, or eliminate Federal/State taxes—legally. U.S. Tax Planning Corporation conducts seminars for doctors nationally (see advertisement this issue). For information, call toll-free 1-800-543-3000-operator, 220 anytime.

**Physician's assistants** — Become a warrant officer in the Pennsylvania Army National Guard in a unit near your home. Serve one weekend a month and a fifteen (15) day annual training period each year. You will be eligible for continuing professional education, monthly pay, and a substantial non-contributory retirement plan. Enjoy the personal satisfaction of doing an important job for your state and nation. For further information contact Major Eugene P. Klynoot, Department of Military Affairs, Pennsylvania Army National Guard, Annville, PA 17003. Telephone (717) 783-3430.


## Family Practitioners

**A progressive and growing Pennsylvania community needs a physician to establish practice in family medicine. Located 40 miles west of Philadelphia and in the center of the mid-Atlantic area, Pottstown offers a business-industrial-residential setting for a practice in a rural-suburban three county area.**

**Available is a new 300-bed community medical center, excellent schools and colleges, and all recreational facilities.**

**Supportive physicians and possible financial aid make this a real opportunity to practice medicine in a most desirable location.**

**For information,**
**telephone (215) 327-7006, or write to**
**Mr. Anthony R. Brasacchio/**
**c/o Pottstown Memorial Medical Center/**
**Pottstown/PA 19464.**

## Third Annual Symposium
## *Nuclear Cardiology for the Practicing Physician*
### July 27-30, 1980
### Hilton Head Inn
### Hilton Head Island, South Carolina

This exciting two and one-half day program will cover current topics in:

- the application of radionuclide ventriculography
- cardiovascular nuclear medicine — office practice
- multiple pinhole imaging and other tomographic cardiac imaging techniques
- equipment selection
- positron imaging

The program meets the criteria for 20 credit hours in Category I of the Physicians Recognition Award of the American Medical Association.

**For further information contact Jagmeets Soin, MD, Program Director, Division of Nuclear Medicine, Medical College of Wisconsin, 8700 West Wisconsin Avenue, Milwaukee, Wisconsin 53226; (414) 257-5322.**

**Reservation deadline June 1, 1980.**

## Residency in physical medicine and rehabilitation

Dynamic, young program with balanced academic and clinical emphasis under the supervision of ten physiatrists. Three year program and integrated internship residency with opportunity for research and pursuit of special interests both in medical school and private hospital settings.

Stipends from $14,900 to $17,000 depending on qualifications. We will pay for visits in selected cases.

**Equal Opportunity/Affirmative Action employer.**

**Telephone or write for information to:**
**John F. Ditunno, Jr., M.D., Director**
**Department of Rehabilitation Medicine**
**Thomas Jefferson University Hospital**
**11th and Walnut Streets**
**Philadelphia, PA 19107**
**Telephone: (215) 928-6573**

*Morris E. Chafetz, M.D.,*
*Founding Director of the National*
*Institute on Alcohol Abuse and Alcoholism,*
*is pleased to announce*
*the opening of a private*
*residential alcoholism treatment facility*
*in Charleston, South Carolina.*

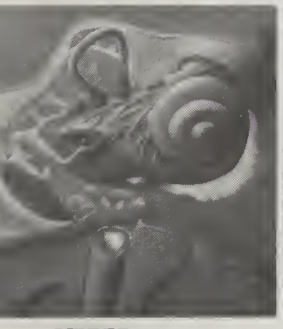
# FENWICK HALL

*John H. Magill, Executive Director. Layton McCurdy, M.D., Medical Director*
*P.O. Box 688, Johns Island, South Carolina 29455. Phone 803-559-2461*

# BACTRIM™ ROCHE
(trimethoprim and sulfamethoxazole)

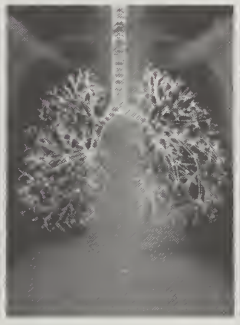
## *A MAJOR ANTIMICROBIAL WITH MULTISYSTEM USEFULNESS*

The clinical usefulness of Bactrim continues to grow. Now Bactrim is useful for all of the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):



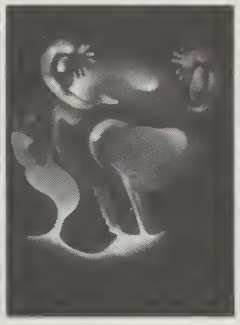
***UPPER RESPIRATORY***

acute otitis media in children



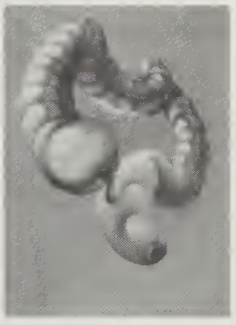
***LOWER RESPIRATORY***

acute exacerbations of chronic bronchitis in adults —documented *Pneumocystis carinii* pneumonitis



***GENITO-URINARY***

recurrent urinary tract infections



***GASTRO-INTESTINAL***

shigellosis

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

**For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.**

**For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.**

**For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.**

**Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.**

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancie

**Dosage: Not recommended for infants less than two months of age.**

*URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:*

*Adults:* Usual adult dosage for urinary tract infections — 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

*Children:* Recommended dosage for children with urinary tract infections or acute otitis media — 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

*For patients with renal impairment:* Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 3 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

*ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:*

*Usual adult dosage:* 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

*PNEUMOCYSTIS CARINII PNEUMONITIS:*

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose™ packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose™ packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; cherry flavored—bottles of 16 oz (1 pint). *Suspensian,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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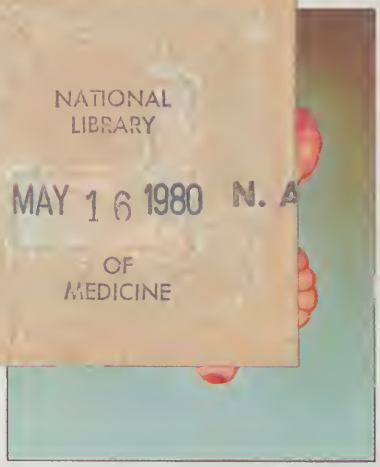

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OF
MEDICINE

ROCHE

# BACTRIM™

(trimethoprim and sulfamethoxazole)

## A major antimicrobial with multisystem usefulness

Clinical applications for Bactrim continue to grow. Now Bactrim is useful for all of the following infections when due to susceptible strains of indicated organisms (for specific organisms, see indications section in product information on other side):

1. *UPPER RESPIRATORY* —acute otitis media in children
2. *LOWER RESPIRATORY* —acute exacerbations of chronic bronchitis in adults;documented *Pneumocystis carinii* pneumonitis
3. *GENITOURINARY* —recurrent urinary tract infections
4. *GASTROINTESTINAL* —shigellosis

☐Dual action minimizes development of resistance
☐*In vitro* spectrum includes ampicillin-resistant *H. influenzae*
☐May be used in patients allergic to penicillins and cephalosporins
☐B.I.D. dosage (except for *Pneumocystis carinii* pneumonitis) encourages compliance
☐Contraindicated during pregnancy and lactation and in infants less than 2 months of age

*BACTRIM — EFFECTIVE, ECONOMICAL AND CONVENIENT B.I.D. DOSAGE*

Please see preceding page for summary of product information.

W1
PE385K

Pennsylvania Medicine

Vol. 83, No. 6 JUNE 1980

SECOND COPY

# 1980 Bylaws

## Proposed revision

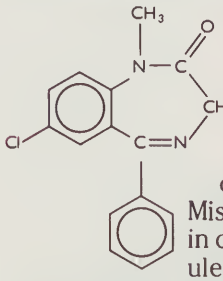
2442
NLM IND MED TITLES
P O BOX 517

BERWYN PA 19312

*Aspects of Management*

# What to tell your patients when you prescribe Valium® (diazepam/Roche)

## Survey shows significant correlation between comprehension and compliance




A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.* Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy. Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

## What Valium (diazepam/Roche) can do

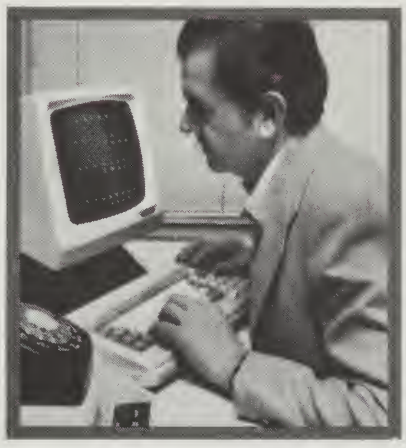
Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.



## What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

**Before prescribing, please consult complete product information, a summary of which follows:**

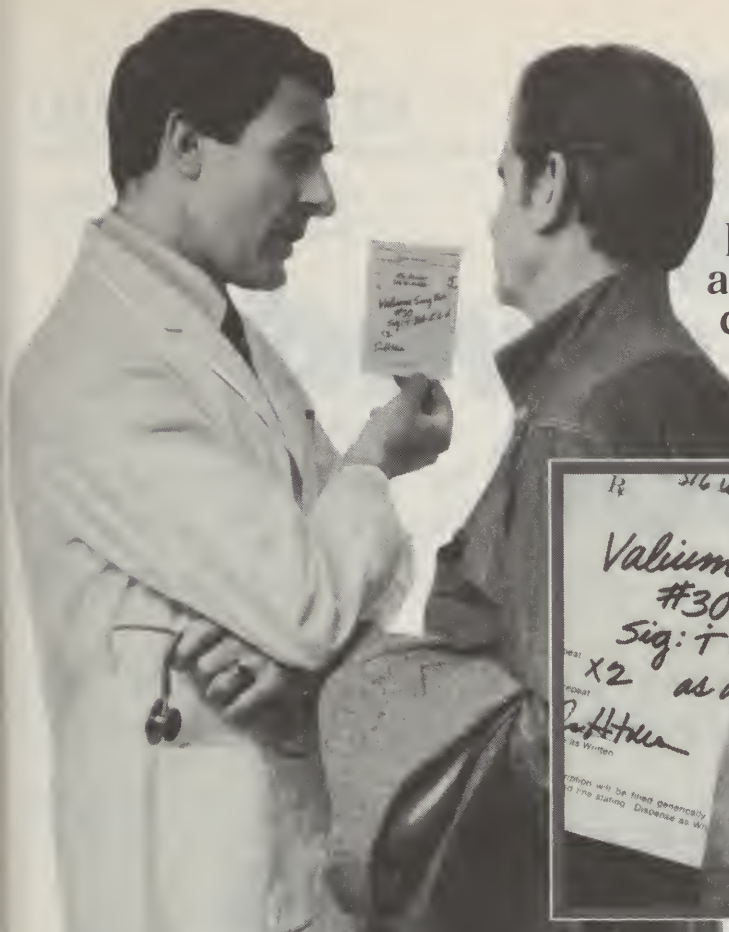
**Indications:** Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics,




# Practical pointers on taking antianxiety medications

**do's** Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

**and don'ts** Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

*2-mg, 5-mg, 10-mg scored tablets*

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## diazepam/Roche

## An important adjunct to your treatment program for excessive psychic tension

barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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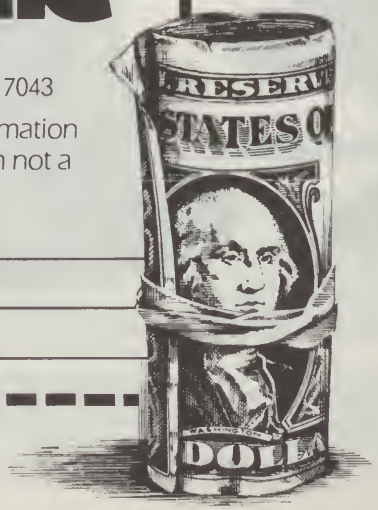


# medigram

**2,500 MEMBERS RESPOND TO CALL FOR MA REFORM**

The Society is still receiving responses to the call of President Matthew Marshall, Jr., MD, for support from members in the quest for reforms in the state's medicaid program. Nearly 2,500 physicians who said they will participate have received action kits containing the PMS Position Paper on Medicaid, a list of legislators, and letter-writing aids for both physicians and the medicaid patients they treat. Society leaders said that hundreds of letters have gone to legislators, and that the barrage must continue. The Society's objective is to raise the medicaid office fee to $15 and to improve other areas of the medicaid program. The Department of Public Welfare has proposed a fee increase from $6.00 to $8.00. The Legislature has the power to increase physicians' fees to $15 for an office visit, and to reform the fee schedule for procedures. Contact the PMS Council on Medical Economics for further information.

**PMS EDUCATIONAL TRUST SENDS SOS TO MEMBERS**

PMS members received in May a plea for contributions to the Educational and Scientific Trust. The fund's $325,000 in low interest (4.5%) loan money is needed to assist the 127 medical students currently being aided, meaning no funds are available for first year students in medical school this fall. The trust hopes to raise $100,000 through the special mailing to members, James Z. Appel, MD, chairman, said. Checks should be made payable to the Educational and Scientific Trust and mailed to the Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043. Contributions are tax deductible.

**DPW EMERGENCY ROOM RULES ALLOW FEES FOR SOME CARE**

Physicians who provide services in hospital emergency departments on a fee for service basis may now bill DPW directly. Regulations published in the Pennsylvania Bulletin April 12 permit such billing by physicians who are not paid for the services by the hospital. Physicians may call the Department of Public Welfare Provider Enrollment at (717) 783-8827 for details and forms. The hospital's policy should be determined also.

**PHYSICIANS TO NUMBER 600,000 BY 1980 IN U.S.**

The Office of Technology Assessment of the U.S. Congress has predicted a physician population of 600,000 in the United States by 1990. The American Medical Association's count of physicians at the beginning of 1978 was 381,969. The Department of Health and Human Services (DHHS, HEW's new name effective May 7, 1980) has chartered the Graduate Medical Education National Advisory Committee to make recommendations on the need for physicians by specialty and location, and on methods for financing graduate medical education programs. The Bureau of Health Manpower of

DHHS also is studying the projection in the OTA report, "Forecasts of Physician Supply and Requirements." Copies are available for $3.75 from the U.S. Government Printing Office, Washington, DC 20510.

THORNBURGH NAMES BARTLE ACTING ATTORNEY GENERAL

Harvey Bartle, III, is the Commonwealth's acting attorney general. The former insurance commissioner was appointed May 20 by Governor Dick Thornburgh. James Farley, formerly chief counsel for the Insurance Department, was appointed acting insurance commissioner. The changes come as the Insurance Department wrestles with problems of the state's Catastrophe Loss Fund established under Act 111 of 1975 to cover malpractice awards in excess of $100,000.

PAVE SETS 1981 GOAL, REAFFIRMS COST VOW

The Pennsylvania Voluntary Effort (PAVE) has set its health care cost containment goal for 1981. A joint project of the Pennsylvania Medical Society and the Hospital Association of Pennsylvania, PAVE has a 1981 target of a 1.5 percent deceleration in the rate of increase of community hospital expenditures. Since PAVE was established, hospital cost increases have been less than increases in the Consumer Price Index. In the past 12 months the CPI increased 14.7 percent; the hospital segment increased 12.3 percent; and medical care only 11.2 percent.

PMS MEMBERSHIP SURVEY BASIS FOR PLANNING

A four-page survey was mailed to every PMS member at the end of May. Its purpose is to provide data for the Committee on Planning and Evaluation of the PMS Board of Trustees. The questionnaire on PMS programs and priorities was contracted out to Research for Management, a division of Hay Associates, the international management consulting firm based in Philadelphia, which will tabulate answers and collate the data for use by the committee.

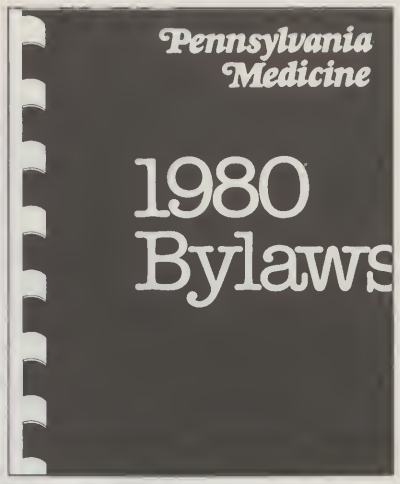
FOUNDATION SCHEDULES JUNE PLANNING SESSION

The Pennsylvania Medical Care Foundation's Executive and HMO-IPA Committees will hold a planning meeting on 1981 priorities and budget June 28-29 at Clarks Summit. Guests will include H. Arnold Muller, MD, secretary of health; Robert Zelten, PhD, of the University of Pennsylvania's Wharton School; Robert Herrick, Pennsylvania Association of HMOs; representatives of Blue Cross and Blue Shield; and members of the Boards of the Foundation and the State Society.

CAT FUND SURCHARGE MUST REFLECT TOTAL PREMIUM

Thomas J. Judge, Sr., administrator of the state's Catastrophe Loss Fund, has ruled that the surcharge paid to the fund by a physician must reflect the sum of malpractice insurance premiums the physician pays. In other words, if a physician has different policies for different aspects of practice, e.g. emergency department and family medicine, he must pay a surcharge on the sum of the premiums for the insurance which covers his practice.

Pennsylvania Medicine

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**PENNSYLVANIA MEDICINE**
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

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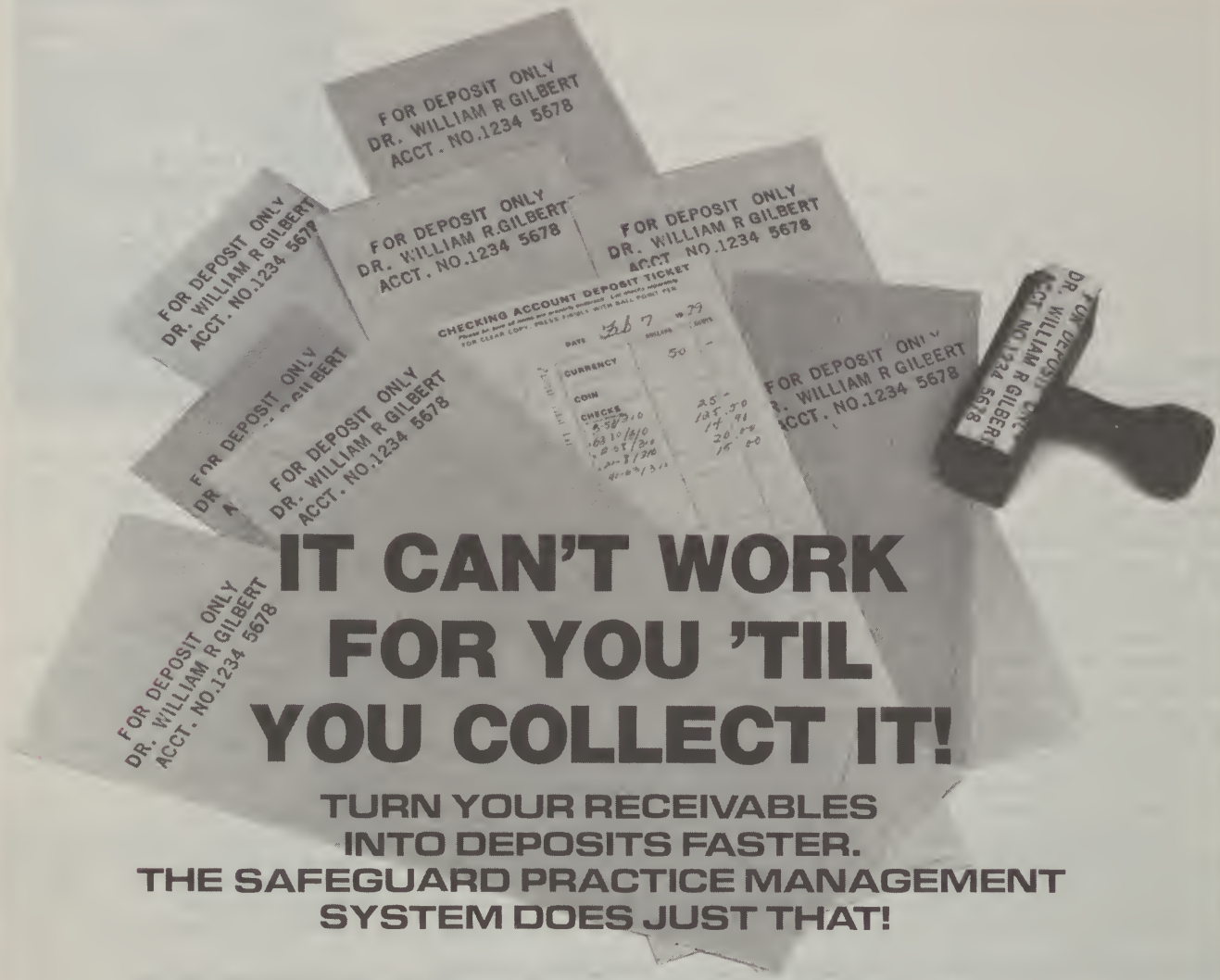


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# editorial

## Breaking the habit of routine and survey x-rays

John L. McClenahan, MD, wrote in 1969 in his article, "Wasted x-rays," that "many 'survey examinations' of colons, chests, and breasts of asymptomatic patients are carried out in order to uncover unsuspected disease. . . [A] great deal of money and radiation are spent uncovering a single patient with tuberculosis whose tuberculin test is negative, one patient with a malignant polyp of the colon that is not bleeding, and one patient with carcinoma of the stomach that is not causing symptoms." (PENNSYLVANIA MEDICINE, November 1969)

In earlier literature, (*Journal of the American Medical Association*, April 18, 1966) Katherine R. Boucot, MD, chairman of the preventive medicine department at Woman's Medical College, reported that the results of semiannual chest x-rays for "early" detection of lung cancer were "discouraging." "Since so significant a percentage of lung cancers are already incurable at the time of radiologic detection, there is an urgent need to develop new methods of detection such as skin or serologic tests."

Today, some 16 years after screening chest x-ray results were termed discouraging, the American Cancer Society has recommended that annual chest x-rays and sputum cytology not be performed because these studies have proved unsatisfactory in reducing lung cancer related death. Gerald Dodd, MD, chairman of the radiology department at M.D. Anderson Hospital and Tumor Institute, commented on the recommendation, "The yield has been so low, that it doesn't seem to justify the expense in time or money." (*American Medical News*, April 4, 1980)

The Pennsylvania Medical Society has endorsed a position on the limitation of x-ray screening programs. The Society will advise the public that "all survey examinations designed to find and treat ailments in the general population should be done only when the disease to be discovered is widespread enough and potentially dangerous enough to warrent exposure of large numbers of people to ionizing radiation."

Various figures have been assigned to human exposure to ionizing radiation from medical and dental sources. Despite these variations, it is accepted generally that medical x-rays constitute the largest single source of exposure. Radiation is acknowledged as a cause of cancer.

Other radiologic screening practices that yield little or no result should be reviewed. These include full spine x-rays, chest x-rays for tuberculosis in food workers, routine hospital admission chest x-rays and routine dental x-rays. Papers which have appeared in the recent medical literature seem to indicate that hospital admission chest x-rays in the under 30 age group succeed only in exposing the patient to unnecessary radiation.

The American Cancer Society change in policy should not lead us to assume that all early detection programs are valueless. Screening tests need not be expensive or sophisticated. They must be effective.

Physicians should educate their patients and discipline themselves to be less dependent upon performing expensive tests. Physicians should request and accept only medically indicated studies. A great deal of time and money may be saved by adopting these attitudes. Perhaps the reward will be less radiation-induced disease and a healthier population.

David A. Smith, MD
Medical Editor

### Book review

## Behavioral medicine for clinicians

Two members of the psychiatry department at the University of Pennsylvania School of Medicine have provided an overview of behavioral medicine for clinicians. Ovide F. Pomerleau, PhD, and John Paul Brady, MD, are co-editors of *Behavioral Medicine: Theory and Practice*.

The editors define behavioral medicine in two ways: "the clinical use of techniques derived from the experimental analysis of behavior — behavior therapy and behavioral modification — for the evaluation, prevention, management, or treatment of physical disease or physiological dysfunction; and the conduct of research contributing to the functional analysis and understanding of behavior associated with medical disorders and problems in health care."

First the editors elucidate the historical antecedents and the basic concepts within this discipline, and then they go on to review the literature for the important clinical applications of behavioral techniques. The early chapters describe the development of learning theory, concisely and understandably. Subsequent chapters provide a detailed introduction to biofeedback and self-control theory and technology.

Fortunately, the bulk of the book is devoted to clinical applications of behavioral medicine techniques. This portion may be of most interest to the clinician. These chapters are candid, up-to-date, and useful reviews of the literature on various clinical applications. They clearly describe the evolution of various treatment techniques, showing their failures and promise. Covered are such problems as aggression, enuresis, encopresis, anorexia nervosa, asthma, chronic pain, muscular tension syndrome, sexual dysfunction, hypertension, smoking, obesity, and alcoholism.

*Behavioral Medicine: Theory and Practice* is a concise and readable work. The clinical entities discussed touch nearly every clinician in his daily practice. This up-to-date book can help us guide our patients in choosing from among the myriad treatment strategies beckoning to them. I recommend this as an excellent introductory work in the field of behavioral medicine.

Lee C. Miller, MD, Director, Division of Psychiatry
Polyclinic Medical Center, Harrisburg

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# PMS House of Delegates to vote on bylaws revision

Dr. Templeton

One major business item to be presented to the 1980 PMS House of Delegates is a proposed revision of the Constitution and Bylaws. In an interview with PENNSYLVANIA MEDICINE, John Y. Templeton, III, MD, chairman of the Constitution and Bylaws Committee, offered some insights into the work his committee has done and into the proposed revision.

**Why has the committee undertaken the task of revising the Constitution and Bylaws?**

In the current Bylaws, it states our committee "shall constantly study the Constitution and Bylaws and recommend revisions and modifications necessitated by changing times, methods, or conditions."

The Society is governed by a Constitution and Bylaws written in 1914 and amended almost annually. In 1977 the committee took a voluntary look at what then governed the Society and recognized an inherent problem when working with two documents. In some cases, the Bylaws contradicted the Constitution. Provisions were added to one document and not the other. The committee became convinced that the two separate documents wuld not work so well as one comprehensive governing document.

Resolution 78-1 adopted by the PMS House of Delegates in 1978 and proposed by the Standing Committee on Constitution and Bylaws sanctioned the committee's work on revising the Constitution and Bylaws. During two years of research, rewriting, and reevaluation, the committee has prepared a single document by which the Society can be governed.

**What is the most important change in the Constitution and Bylaws?**

In the proposed revision we are submitting one document for approval to the House. This single document combines the governing principles in both the Constitution and Bylaws. We are calling the revision, the Bylaws, because according to *Sturgis Standard Code of Parliamentary Procedure* it is "old-fashioned and cumbersome" to have both a constitution and a set of bylaws. *Sturgis* recommends that the bylaws is preferable to a constitution.

According to the statutes in Pennsylvania, all that is required is the articles of incorporation. Thus, the Society's Articles of Incorporation and the proposed Bylaws will fulfill the legal requirements and the procedural recommendations.

In effect, we have not eliminated the Constitution; we have changed its name to Bylaws and added some governing principles that were in the Bylaws. Thus we present one comprehensive document, the Bylaws, as required by law.

**How did the committee arrive at its revision?**

We began with the current Constitution and used it as the core document. We then considered each section of the Bylaws and integrated it with the corresponding section of the Constitution.

We found that for the most part the two documents were repetitive. In these instances we worked toward presenting one single section whose language was simple and whose principles were workable. In most of the proposed changes, the essence of the Constitution was retained.

**What did you do when the Constitution differed from the Bylaws?**

We used the Constitution as the core document as I already said. We considered the Bylaws amendments and

---

*John Y. Templeton, III, MD, is a general and thoracic surgeon in Philadelphia. He is past president of Philadelphia County Medical Society. He is a member of the State Society's Advisory Committee on Professionalism and its House of Delegates. Other members of the Constitution and Bylaws Committee are Norman A. Goldstein, MD, Wayne W. Helmick, MD, Robert M. Jaeger, MD, and Ralph J. Stalter, MD.*

Dr. Templeton and Dr. Jaeger

using our other research tools we determined the governing principle and included it in our proposed revision. In almost every instance of a difference. between the Constitution and Bylaws we determined that the governing principle in the Constitution prevailed in the proposed revision.

**What review procedures did the committee use?**

All sections of the proposed revision were reviewed by the appropriate PMS staff, legal counsel, the Executive Vice President, and Betty L. Cottle, MD, consultant to our committee. Dr. Cottle had been chairman of the PMS Committee on Constitution and Bylaws for five years. She now is a member of the AMA Committee on Constitution and Bylaws.

**How can the membership know what has been changed?**

In presenting our proposed revision, we have prepared an explanatory document, an analysis, of the proposed revision. In this analysis we cite the referred section of the current Constitution or the current Bylaws and offer a brief description of the changes made. This document will accompany the proposed revision in its publication in PENNSYLVANIA MEDICINE. The changes are of two types: editorial or substantive.

**Can you give a few examples of editorial changes?**

Yes, there are three that would be indicative.

1. The first chapter of the proposed revision deals with membership. In the current Constitution and Bylaws there seem to be at least ten different categories of membership. In fact, there are five: active, associate, affiliate, honorary, and special student member.

The proposed revision clarifies this and also details the variations within the active member category in simpler, contemporary language. These variations include senior, federally employed, and graduate-in-training members to name a few.

2. We have changed the designation of trustees and districts by eliminating the word, councilor, from their titles. The designation of councilor is obsolete, whereas trustee is simple and all encompassing. This simpler reference is used throughout the proposed revision. The duties of trustees and the districts they represent remain unchanged. We have not altered the responsibilities of the trustees to the PMS Board or their respective districts.

3. The committee has adopted *Sturgis* recommendation to use the term, session, only when referring to a specific meeting of the House of Delegates. The period previously referred to as Annual Session will be called Annual Meeting and each day of a meeting of the House will be a session.

**Can you give a few examples of substantive changes?**

Yes, and again I will mention three which are indicative.

1. Upon a previous decision of the House of Delegates, we have elimi-

## Renal disease program funds treatment for 3,000

The Pennsylvania Department of Health recently announced that the Chronic Renal Disease Services program spends $4.4 million a year for treating about 3,000 patients.

Mandated by legislation ten years ago, the program was implemented to provide lifesaving care and treatment of chronic kidney patients who were unable to pay for such services.

The program pays costs not covered by medicare, medicaid, Blue Cross and other insurance.

According to program manager Elaine M. Terrell, MPH, the program serves both dialysis and transplant patients at an average cost of $1,307 per patient a year.

## Psychiatric glossary available from APA

The American Psychiatric Association has published the fifth edition of *A Psychiatric Glossary*. The glossary contains more than 1,000 definitions of psychiatric terminology and descriptions of contributors to the field.

The reference book also includes seven tables and a list of 85 commonly used abbreviations. New listings in biologic psychiatry and in neuroscience were added.

Copies are available from the Publications Sales Office, American Psychiatric Association, 1700 18th Street, N.W., Washington, D.C. 20009 for $5.95 each. Hardcover editions for $9.95 can be ordered from Little, Brown and Co., 200 West Street, Waltham, MA 02154 (order no. 036-560).

## Board recommends no smoking policy

David J. Keck, MD, chairman of the PMS Board of Trustees, has urged all Society committees, councils, and commissions to observe the smoking policy adopted by the Board at its April 9, 1980 meeting.

According to the policy, no smoking is recommended at Society committee meetings. The policy also recommends that appropriate posting of information and alternatives to handling smoking situations be considered.

nated the section on scientific and general meetings. The House discontinued scientific meetings years ago and the Society no longer holds general meetings.

2. In the current Constitution, district censors are listed as officers. This conflicts with the separation of powers since district censors are in the judicial branch of the Society. They do not function as officers; they function in a disciplinary capacity and should not be considered as officers.

The committee also suggests that district censors be elected by component societies at their regular meetings and not at a meeting of the House of Delegates.

3. In the proposed revision we have provided that the speaker and vice speaker of the House of Delegates have a vote on the Board of Trustees. The committee unanimously agreed that this could broaden and strengthen the representation of the House on the Board of Trustees.

**Are there any other important features of the proposed revision?**

Yes, I would like to mention the important areas in which no changes have been made.

- The responsibilities and the duties of the Board of Trustees have not been changed.
- The separation of powers in the Society's structure has not been changed.
- The procedures for representation in the House of Delegates have not been changed.

**How will the proposed Bylaws be amended?**

Since we used the current Constitution as the core document, we want to protect the proposed Bylaws with a stricter amendment process than the 24-hour procedure used in the current Bylaws. For this reason, we will retain an amendment procedure similar to that of the current Constitution. This will ensure that any proposal will receive adequate review by the House of Delegates.

**What impact will the proposed revision have on the Society?**

PMS Secretary G. Winfield Yarnall, MD

The proposed revision will provide the Society with one comprehensive set of governing principles. The format of the new Bylaws will lend itself to easier reference and understanding. The committee is confident that the proposed revision represents the governing principles of the Society as it is today.


## Institute for Medical Education and Research

### Geisinger Medical Center

### 1980-1981 Continuing Education Programs

**Annual Rheumatology Seminar**/Wednesday, September 10, 1980/9 a.m. to 5 p.m./$55

**Poison Update**/Tuesday, September 16, 1980/9 a.m. to 5 p.m.

**Practical Solutions to Common Problems in Family Medicine**/Wednesday, September 17, 1980/1 p.m. to 5 p.m./$30

**Management of Acute Neurological Problems**/Wednesday, October 1, 1980/9 a.m. to 5 p.m./$55

**I.V. Therapy Program**/Wednesday, October 8, 1980/9 a.m. to 5 p.m.

**Gastrointestinal Disease: Update on Diagnostic & Surgical Techniques**/Wednesday, October 15, 1980/9 a.m. to 5 p.m./$55

**6th Annual Emergency Medicine Seminar**/Wednesday, October 22, 1980/9 a.m. to 5 p.m./$55

**Common Problems, Challenging Cases, and Frequent Pitfalls in Allergy**/Wednesday, October 29, 1980/9 a.m. to 5 p.m./$55

**Advances in Pediatrics**/Thursday, November 13, 1980/9 a.m. to 5 p.m./$55

**Critical Care Medicine-1980***/Friday, Saturday, & Sunday, November 14-16, 1980

**Concepts in Clinical Practice***/Friday, Saturday, & Sunday, February 13-15, 1981

**Current Dental Procedures**/Wednesday, February 25, 1981/9 a.m. to 5 p.m.

**Venereal Disease Update**/Wednesday, March 4, 1981/1 p.m. to 5 p.m./$30

**Otolaryngology Update for Primary Care Physicians**/Wednesday, March 18, 1981/9 a.m. to 5 p.m./$55

**Occupational Health Nurse Program***/Saturday, March 28, 1981/9 a.m. to 5 p.m.

**Current Concepts in the Rehabilitation of the Stroke Patient**/Wednesday, April 1, 1981/9 a.m. to 5 p.m./$55

**Problems in Neuro-Ophthalmology***/Saturday, April 11, 1981/9 a.m. to 1 p.m./$30

**Advances in Practical Dermatology**/Wednesday, April 15, 1981/9 a.m. to 5 p.m./$55

**Problems in Vascular Disease**/Wednesday, April 22, 1981/9 a.m. to 5 p.m./$55

**13th Annual Special Child Conference***/Saturday, May 2, 1981/9 a.m. to 1 p.m.

**2nd Geisinger Nutrition Symposium***/Friday & Saturday, May 15-16, 1981

**Thyroid Disease Update: 1981***/Saturday & Sunday, May 30-31, 1981/Pocono Hershey

**Congestive Heart Failure:** Reversible Causes and Management/Wednesday, June 10, 1981/9 a.m. to 5 p.m./$55

**Annual Pocono Course***/Wednesday to Sunday, August 12-16, 1981

**Weekend course*

As an organization accredited for continuing medical education, Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. (Refer to each program: full day, 7 hours credit; half day, 4 hours credit.)

**For further information write to Millie K. Fleetwood, Ph.D., Geisinger Medical Center, Danville, PA 17821 or telephone (717) 275-6925.**

# State bureau of rehabilitation seeks physicians

Career opportunities are available for family medicine practitioners and most other specialists in the Disability Determination Division of the Pennsylvania State Bureau of Vocational Rehabilitation.

The work, administrative in nature, involves reviewing cases and applying Social Security Administration medical regulations. Interesting and unusual cases are reviewed with attending physicians and claims adjudicators.

Positions are either full- or part-time at each of these state branch offices: Greensburg, Wilkes-Barre, and Harrisburg.

Physicians at these facilities review evidence in claim folders to assure appropriate medical examinations and lab studies, and approve requests for specialty consultations purchased by the Disability Determinations Division. They answer questions dealing with medical issues related to severity of disease and impairment. They do not serve in direct rehabilitative functions, but are consultants and evaluators.

Disability physicians help select claimants for referral to vocational rehabilitative agencies for services. They also assist claim adjudicators with determining claimant functional capabilities. Advancement potential exists through various levels of work and specialization, distinguished from one another by degrees of complexity, responsibility, and supervision required.

Remuneration for entry-level full-time physicians is $25,633-$33,154 per year plus the normal state employes benefits package, which includes generous holiday and vacation leave. Work hours are regular. Night and weekend calls are limited due to the administrative nature of the positions. Part-time physicians working 19 or more hours per week receive pro-rated benefits. Those with specialty qualifications who are interested should contact BVR for a more specific analysis of salary benefits.

The minimum requirements for the entry-level positions are: a degree of doctor of medicine or osteopathy from a State Board-approved school, or a Standard Certification as issued by the Education Council for Foreign Medical Graduates, and completion of an internship in a school or institution approved or recognized by the appropriate State Board. Applicants must have a license to practice medicine in the Commonwealth of Pennsylvania. Neither advancing age nor specialty inexperience is in itself a barrier to duty performance in these mainly administrative positions.

For more information and application forms, contact Gary W. Henning at the Disability Determination Division, Bureau of Vocational Rehabilitation, Department of Labor and Industry, Labor and Industry Building, Harrisburg, Pennsylvania 17120, telephone (717) 783-3620, ext. 418.

## Patients needed for sarcoma treatment studies

The National Cancer Institute needs referrals of patients with primary soft tissue or bony sarcomas to evaluate its new treatment programs.

Any patient with a diagnosis of fibrosarcoma, liposarcoma, rhabdomyosarcoma, osteogenic sarcoma, undifferentiated sarcoma, synovial cell sarcoma, mesenchymoma, angiosarcomas, or any soft tissue mass suspected of being a sarcoma can be referred.

Patients most suitable for the treatment protocols are those who have had incisional or needle biopsy or local excision to confirm the diagnosis.

The Institute will keep referring physicians informed as to the results of treatment and promptly return the patients for joint follow up care. The Institute also will reimburse the patients for care and transportation costs.

To refer a patient or to obtain further information, call or write Ernest V. deMoss, MD, Admitting Officer, Surgery Branch, National Cancer Institute, Building 10, Room 10N119, Bethesda, MD 20205, (301) 496-1533 (collect).

**Matthew Marshall, Jr., MD, PMS president, right, accepted for PMS an award for increasing AMA membership in the state in 1979. Lowell H. Steen, MD, chairman of the AMA Board of Trustees, presented the plaque after he spoke to the PMS Board of Trustees April 9, 1980.**

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JAMES G. BRYAN, Management Consultant and Founder of Doctors Management Consultants, Portland, Oregon, has served the medical/dental profession for many years. A teacher, lecturer, and economist, James Bryan earned his degree at the University of Oregon. He is a recognized authority on Off-Shore Tax Planning, Medical Malpractice Insurance and Tax Straddles.

CARL J. SAVIO, Financial Planning expert and President of Coordinated Professional Services, Philadelphia, Pa., specializes in International Estate Planning, Insurance Options and Tax Havens. An innovator, Savio combines his experience in International Tax Law, Accounting and Business Management to develop sound tax reduction plans for professionals and corporations.

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**Seminar Fee:** $95 for doctors (spouses/office managers free), includes continental breakfast. Fees are tax deductible.

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# Foundation comments on FTC reports, proposed rule

Pennsylvania Medical Care Foundation President Joseph N. Demko, MD, has submitted formal comments on the Federal Trade Commission's staff reports and proposed trade regulation rule published in the March 17, 1980 *Federal Register*.

The reports concern alleged physician control of Blue Shield and other open-panel medical prepayment plans such as individual practice associations (IPAs). The FTC contends that physician control results in higher fees and also restricts competition.

The Foundation's comments reflect the attitude of the PMS Board of Trustees as expressed in Report H to the House of Delegates in November 1979. The Board charged the Foundation to keep physicians informed of the significance of the FTC's report and proposed rule and to assure that the IPA concept remains a viable alternative method of health care delivery and financing.

Dr. Demko's letter to FTC Chairman Michael Pertschuk appears below.

Dear Chairman Pertschuk:

The Pennsylvania Medical Care Foundation, in response to an action of the Pennsylvania Medical Society, has assumed the responsibility of studying and evaluating alternative methods of health care delivery and financing. In its study of the various alternatives, the Foundation has identified the Individual Practice Association (IPA) as an acceptable alternative for physicians who opt for the delivery and financing of health care in an HMO setting. The Foundation has established an IPA-HMO resource center for interested physicians and has been following the activities of the Federal Trade Commission regarding these alternative, competitive health care delivery and financing entities.

The Foundation is concerned about the FTC's inclusion of IPA-type HMOs in its staff reports dealing with the alleged effects of physician participation in the control of Blue Shield and other open-panel medical prepayment plans. A comparison of the two types of plans reveals vast differences. Some of these differences are:

1. IPA-participating physicians are at risk for services provided to plan subscribers, while Blue Shield-participating physicians are not;

2. IPAs must offer 24-hour coverage for physician services, while Blue Shield-participating physicians set their own hours;

3. IPAs do not control the high percentage of the insurance market or include the high percentage of physicians, as do Blue Shield plans;

4. In an IPA, benefits for subscriber services are limited to participating physicians, unlike most Blue Shield plans that will pay for services provided by non-participating physicians;

5. IPAs are structured in various ways, thus making the FTC's contentions about "open-panel" plans and "closed-panel" plans inaccurate and unfair.

In addition to the unfair comparisons of the functions of an IPA-type HMO to Blue Shield plans, there is a notable lack of data and information on the operation of IPA-type HMOs in the FTC's staff reports. While much information was collected regarding Blue Shield plans, no detailed information was presented on operational IPA-type HMOs.

The Foundation believes that, in the FTC's attempts to create a fair competitive setting, stimulate new and innovative competition, and lower overall health care costs, its actions to remove physician participation in certain health care plans could result in exactly the opposite of these goals. The prohibition of IPA-type HMOs, as they currently exist, would remove a competitive force from the health care marketplace that has been successful in reducing the utilization of hospital services, and would discourage physicians from developing other alternative forms of health care delivery and financing in the future.

While the FTC's staff reports raise many questions on the present operations of certain health plans, and how the proposed rulemaking would alter these operations, there is no evi-

## Health department reports venereal disease summary

The yearly summary of venereal disease activity in the state has been released by the health department. For the fifth year gonorrhea is the most frequently reported communicable disease.

Reported cases of gonorrhea among all age groups declined by about 4 percent in Pennsylvania in 1979 but the fourteen and under age group showed about 40 percent increased incidence.

About 700 women were reported with gonococcal pelvic inflammatory disease, a complication of gonorrhea. The complication is costing the U.S. an estimated $560 million a year.

Syphilis, although less prevalent than gonorrhea, increased 41 percent from 1978 to 1979. Of the cases reported, 81 percent involved men, 51 percent of whom named other men as sexual partners.

The figures do not include Philadelphia which has its own reporting and control programs. Of the counties in the state, Philadelphia leads in terms of number of reported cases of gonorrhea and syphilis and rate per 100,000 population.

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**The article, "PSRO mandate includes records review, corrective action" which appeared in the April issue, contained quotations for which, inadvertently, no source was listed. Two paragraphs, the second and third from the end of the article on page 27, were taken from the book, *Medicare and the Physician*, by Jerry Zaslow, MD, of Philadelphia. Dr. Zaslow's book was published in 1979.**

dence presented that the proposed rulemaking would actually cause these changes. Before further action is pursued, the Foundation suggests that national research be conducted to prove or disprove the FTC's assumptions. Such rulemaking should be based on well-researched information, rather than assumptions and anecdotal evidence.

The Foundation is also concerned about the inconsistencies between the Bureau of Economics' report and the Bureau of Competition's report. Although both are branches of the FTC, in some respects the Bureau of Economics' report contradicts that of the Bureau of Competition's assertions and supports the Foundation's position that IPA-type HMOs have procompetitive effects in the health care marketplace. Further, the FTC's proposed actions are also inconsistent with the intent of Congress, which enacted HMO legislation to foster competition. Since the IPA-type HMO has been the fastest developing type of HMO, there is no doubt that any action to minimize physician involvement would slow, if not destroy, momentum in HMO development.

While the FTC alleges, without supporting data, that physician control of an IPA-type HMO creates higher fees than in plans that physicians do not "control," the Foundation has not found the same correlation. With the marketplace pressures on the HMO to offer its package at a competitive premium, and the IPA-physicians "at risk" financially for excess utilization of services, there seem to be pressures to hold costs down, not escalate them, as the FTC suggests.

As for the FTC's suggestion to analyze plans which have more than 50% of the physicians participating in a given area, the Foundation contends that such percentage is irrelevant. Market penetration and other factors need to be taken into consideration. Again, there is an absence of evidence in the FTC's reports that support the "50% rule."

In closing, the Foundation supports a pluralistic approach to the delivery and financing of health care. This approach includes the traditional fee-for-service practice of medicine, HMOs, private insurance, and other mechanisms which tend to make a competitive marketplace. The Foundation believes that the elimination or restriction of physician participation in certain health plans will have a long-term chilling effect on the willingness of the medical community to participate in the development of new programs and methodologies in the delivery of health care.

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**PENNSYLVANIA MEDICINE received the first prize for magazines in the 1980 awards program of Women in Communications, Inc. of Central Pennsylvania.**

**Last year the journal won a first place award for "excellence in design and editorial content," in a national contest for state medical association publications.**

**Women in Communications, Inc. (formerly Theta Sigma Phi) is a national organization of 9,000 communications professionals.**

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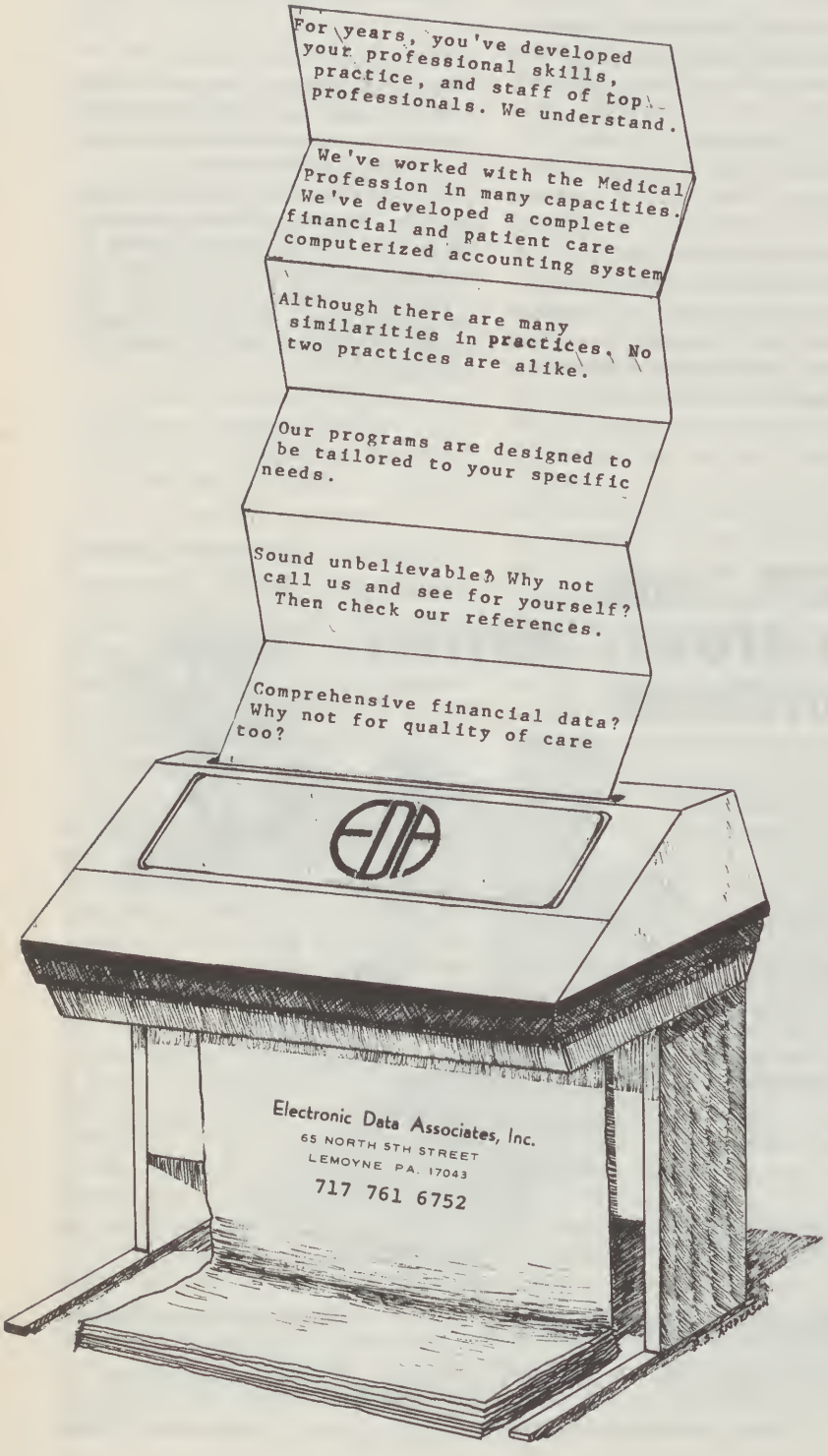


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Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In intants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential tor harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, theretore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined:

*General:* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness ot mouth, nose, and throat.

*Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles.

*Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis.

*Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

*Gastrointestinal System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

*Genitourinary System:* Urinary frequency, ditticult urination, urinary retention, early menses.

*Respiratory System:* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**OVERDOSAGE** Antihistamine overdosage reactions may vary trom central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass ot water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given betorehand. Isotonic and ½ isotonic saline is the lavage solution ot choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

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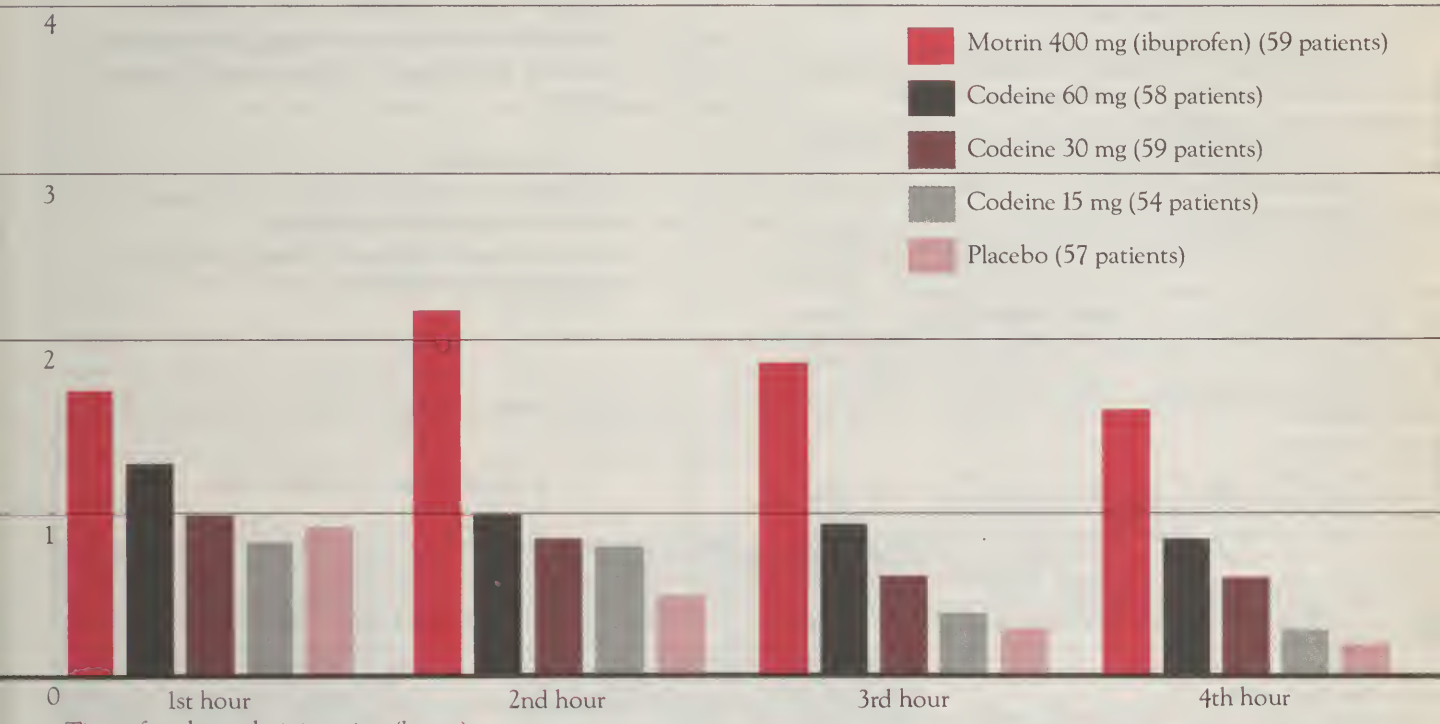


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**Indications and Usage:** Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

***Incidence greater than 1%***

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

***Incidence less than 1 in 100***

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

***Causal relationship unknown***

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

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# Decline of 8% in child abuse noted in department report

The incidence of child abuse in Pennsylvania declined 8 percent in 1979 according to the annual report on child abuse prepared by the public welfare department.

A total of 12,845 child abuse reports were investigated in 1979 compared with 14,086 cases in 1978. The decline is the first lowered incidence since 1968 when the Commonwealth started compiling statistics.

Welfare Secretary Helen O'Bannon said, "While we all hope that child abuse is declining in Pennsylvania, we must also recognize the possibility that people may not be reporting suspected abuse as freely as in the past."

During 1979, 6,427 reports of child abuse were made to county children and youth agencies and 6,418 were made to the welfare department's toll-free ChildLine.

## New manual of mental disorders available

The American Psychiatric Association has published its *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, (DSM-III),* and the companion volume, *Quick Reference to the Diagnostic Criteria from DSM-III.*

These publications represent the first major revision of the psychiatric nomenclature in 12 years.

The new edition introduces sets of diagnostic criteria which, extensive field trials have shown, have improved inter-rater diagnostic reliability. Other features include a multiaxial system for evaluation, and Decision Trees for differential diagnosis.

*DSM-III* is available from Publication Sales, American Psychiatric Association, 1700 18th Street, N.W., Washington, D.C. 20009. The casebound volume costs $25; the softcover is $20. The *Quick Reference to the Diagnostic Criteria,* which contains only the diagnostic classification and diagnostic criteria, is available only in softcover for $10.00.

## Continuing education series available from PSU

The Pennsylvania State University College of Medicine and Independent Study by Correspondence announced its continuing medical education programs for primary care physicians.

*The College of Medicine Presents* is a series of 11 illustrated lectures and the *Physician Update* series features nine lectures.

These 30-minute videocassette programs are designed to update primary care physicians on new developments in various specialties. Some topics included are drug abuse, child abuse, burn care, alcoholism, skin diseases, and ultrasound examinations.

Each program qualifies physicians to earn one hour Category I credit toward the AMA's Physician's Recognition Award. County medical societies and hospital medical staffs may use the programs as group education opportunities.

For rental and registration information contact The Pennsylvania State University, Independent Study by Correspondence, 3 Shields Building, University Park, PA 16802.

## State to train personnel in crib death crises

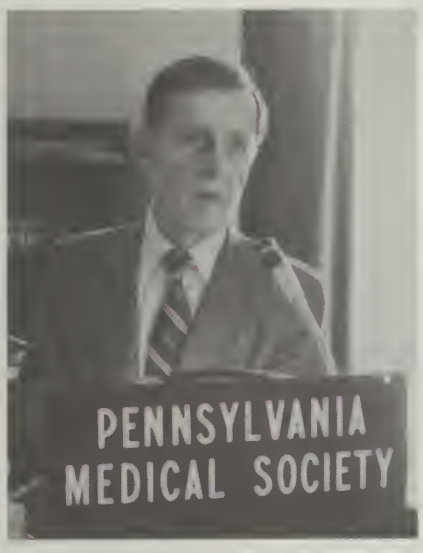
The Parent, Child, and School Health Division of the state health department has developed a crisis intervention, information, and education program to aid families who have lost a child from Sudden Infant Death Syndrome.

David J. Gordon, coordinator of the program said, "Part of our program is designed to train public and emergency health personnel, police, firemen, clergy, coroners, and funeral directors, anyone who would have contact with a family shortly after a crib death."

Of the 6,500 to 8,000 such deaths in the United States annually, Pennsylvania reports 185 to 210, but a more accurate figure may be 370. Thus, another part of the program is aimed to increase professional recognition and identification of crib deaths.

Gordon said, "The consequent increase in the number of autopsies performed in the state will lead to greater collection of data to aid researchers and the health department.

The third phase of the program includes developing parent support groups and educating the community about crib deaths.



**The Pennsylvania Medical Society's School Health Seminar drew more than 150 teachers, physicians, nurses, and administrators to Crossgates Inn, Camp Hill, on May 5. A series of plenary sessions and workshops concerned health and nutrition education, sports medicine, and special health needs in schools. Among the speakers were Kenneth D. Rogers, MD, left, of Pittsburgh, and Glenn S. Bartlett, MD, of Hershey. Dr. Rogers addressed a plenary session entitled "Is there life after school health?" Dr. Bartlett conducted a workshop on sports medicine.**

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At PMS Officers' Conference

# Medicine's leaders discuss issues of the 80s

More than 285 physicians attended the Society's 1980 Officers' Conference, April 23-24 at the Penn Harris Motor Inn. State Society officers, county medical society leaders, and, for the first time, medical staff presidents, were among the participants.

The two day program featured remarks from state secretaries of public welfare and health, the president of the AMA, and urban consumer leaders.

Secretary O'Bannon

**Secretary of public welfare**

An abomination is how Secretary of Public Welfare Helen O'Bannon described the current $6.00 medicaid office fee.

Secretary O'Bannon said, "The medicaid fee schedule does not make sense. It needs to be revamped. It does not reflect modern medicine and it encourages poor economy in medical practice."

Secretary O'Bannon said the public welfare department is working to "adjust emergency room physician fees and to increase fees for participating physicians."

O'Bannon continued, "As it stands, the system is on the brink of collapsing under its own weight."

Despite the impending collapse, O'Bannon said the department is working to enroll "ethical providers who are willing to serve an array of clients."

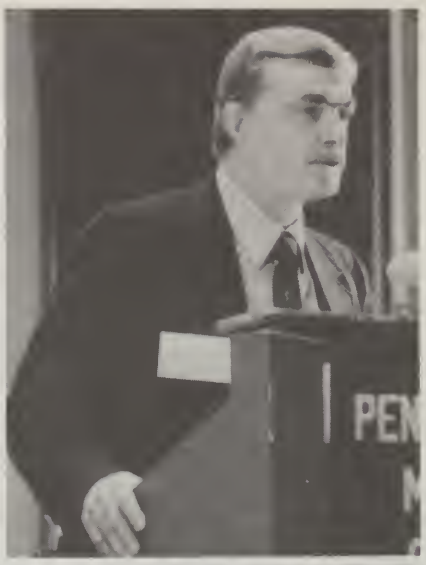
In her prepared remarks, O'Bannon supported the governor's budget and called for an increase in the low physician and surgeon fees under the medicaid program. She also said the department will begin to address the financial problems of long-term care.

**Secretary of health**

H. Arnold Muller, MD, secretary of

Dr. Muller

Dr. Gardner



Dr. Levis

health, presented a Harrisburg perspective on health care in Pennsylvania. Dr. Muller voiced concerns about the crowded condition of the health care field, malpractice claims, and hazardous waste.

Dr. Muller said, "In an era of regulation, we are trying to deregulate." He cited the attempt to consolidate state and JCAH inspections of hospitals. He said, "We are ready to believe JCAH and cut redundancy and cut costs."

### AMA president

Hoyt D. Gardner, MD, president of the AMA, told participants that 40 percent of the resolutions before the AMA House come from the concern of an individual member of a component society. In effect, 40 percent of the AMA's policies and their national and international consequences are initiated by individual physician members.

Dr. Gardner discussed national health insurance. He encouraged physicians to be as tough as the AMA on any proposal. He said, "When the answer to all the following questions is yes, then we in the medical profession can accept national health insurance." Dr. Gardner's questions were:

Will there be — less regimentation? better access? more personal motivation? better kept confidentiality? less politics? less bureaucracy? less cost? and, more compassion and sensitivity?

Dr. Gardner said the health care industry was the second largest industry in the nation. He added, "Of the 10,000 bills before the 95th Congress, 2,000 (25 percent) were related to health care and health delivery."

### AMPAC chairman

Michael P. Levis, AMPAC chairman, spoke on the role of medical political action committees, whose aim is to get good candidates elected and to support good candidates.

Dr. Levis said, "Not enough money is spent on political candidates." He quoted figures for the average contribution of two special interest groups in the health field: "The average PAC contribution from each chiropractor is $500 per year, compared with $11.75 yearly from physicians."

### Disadvantaged health consumers

Matthew Marshall, Jr., MD, moderated a panel on the disadvantaged health care consumer. Panelists were Mr. Carl Moore, chairman of the South Philadelphia Health Action and Mr. Arthur Edmunds, executive director of the Urban League of Pittsburgh.

The panelists discussed problems of the health care consumer in the inner-city. Mr. Moore's and Mr. Edmund's remarks will be published in a subsequent issue of PENNSYLVANIA MEDICINE.

### Medical staff bylaws quiz

Fred Speaker, legal counsel for the state Society, presented a medical staff bylaws quiz to the audience. The quiz presented common legal problems that involve physicians who serve on hospital staffs.

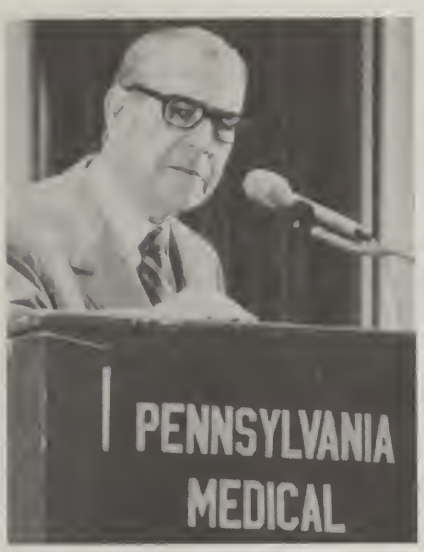
### Donaldson lecture

The 1980 Donaldson Memorial Lecturer was Tim Lee Carter, MD, Republican Congressman from Kentucky. In "The Outlook for Health Legislation in 1980," he named interferon research as an area where the legislature will be active this year.

Regarding the voluntary effort, Dr. Carter said he felt, "The voluntary effort contributed directly to the defeat of President Carter's hospital capitation proposal."

When asked how to tackle the problem of cost containment, Dr. Car-

Mr. Moore and Mr. Edmunds



Dr. Carter

Dr. Demko, Mr. Speth, and Mr. Schmidt

ter said, "Use the PSRO. They are here both to ensure quality care and to limit costs."

**Power in the hospital**

Paul F. Kase, MD, chairman of the PMS Council on Health Planning and Facilities, moderated a panel on "Power in the Hospital." Participating as panelists were Joseph N. Demko, MD, president of the medical staff at Community Medical Center, Scranton; Bernard Schmidt, chairman of the board, Harrisburg Hospital; and Albert W. Speth, administrator of Lock Haven Hospital.

The panelists agreed that a hospital had to define its role in the community but each panelist held a separate conviction of what the role should be.

The panelists also agreed that physicians should serve on boards of trustees or directors of hospitals. They could not agree on the qualifications of such physicians except that interest on the physician's part was necessary.

**Political analyst**

Kevin Phillips, president of the American Political Research Corporation, discussed the 1980 elections, "The Stakes and Probabilities." He analyzed the upcoming election in terms of various historical political cycles.

**Prayer breakfast**

Jay W. MacMoran, MD, chairman of the Commission on Medicine, Religion and Bioethics, discussed faith and the healing process at Thursday's prayer

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Dr. Marshall and Dr. Grandon

breakfast. Dr. MacMoran described qualities of faith and of the healing process and suggested bridges which would connect the two.

**Benjamin Rush awards**

William A. Shaver, MD, chairman of the PMS Council on Member Services, presented the Benjamin Rush Awards to the state winners.

Mr. Hyman "Hy" Hurwitz, a retired high school science teacher and community leader from Butler County, received the individual award. Hurwitz is a volunteer speech aid in Butler VA's audiology and speech pathology service.

He became completely paralyzed on one side of his body and was unable to speak after surgery for cerebral aneurysm in 1971. As a volunteer at the VA, Hurwitz helps other stroke victims learn to walk and talk again.

The group award went to the Pittsburgh Pinch Hitters, Allegheny County, a group of Pittsburgh Pirates' wives and others associated with baseball. The group raises funds for charitable causes and last year helped to establish in Pittsburgh a Ronald McDonald House where parents from western Pennsylvania may stay while their children are treated in Pittsburgh area hospitals.

**Environmental awards**

Matthew Marshall, Jr., MD, PMS president, presented the Environmental Improvement Awards to the state winners.

The voluntary agency award went to Camp Kon-O-Kwee, Beaver County, operated by the Pittsburgh YMCA. The camp offers an environmental education program for some 1,800 youths from western Pennsylvania.

RACE (Runners Act to Clean Environment) of State College, received the community award.

RACE asks that, while jogging, its members pick up and discard properly at least two cans or bottles. The club was the brainchild of Arthur V. Ciervo, Penn State's director of public information, and Dr. Robert J. Scannell, dean of the College of Health, Physical Education, and Recreation at the Pennsylvania State University, University Park.

The individual awards were shared by Raymond D. Shaffer and Mark N. Witmer (posthumously), of Dalmatia, for their leadership in the Northumberland County Conservation District.

Mr. Witmer had been active on the first board of district supervisors of the Northumberland Soil Conservation District in 1943. He helped turn Stone Valley into a national showplace of contour farming. Mr. Shaffer served more than 24 years as district director and board chairman.


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# practice management

## Increase in physicians affects practice arrangements

**Leif C. Beck, LL.B., CPBC**
**Vasilios J. Kalogredis, JD, CPBC**
**Geoffrey T. Anders, JD CPA**

The increasing number of new physicians finishing medical school and residency training each year is becoming more and more a factor in health planning. *The Wall Street Journal* recently featured the trend in a front page article exploring the "surplus of MDs."[1] As management consultants and attorneys for medical groups and individual physicians, we are particularly concerned about what this fast-developing trend will mean to our clients.

The subject so far has had little written comment, because it is sneaking up rather quietly on physicians. We consider this article one of the first critical discussions of how the increasing doctor supply actually is affecting medical practice arrangements. These effects vary depending on the age, specialty, and experience of the doctor(s) involved. As the supply/demand situation moves inexorably onward, the effects continue to change.

### Hiring a new associate

Medical practices over the past ten years have been generous in hiring new doctors. Other professionals, particularly attorneys and accountants, were hard put to understand their doctor-clients' hiring at $40,000 salaries and creating full income parity in just two or three years. Yet the nature of medical practice and the competition for additional well-qualified specialists justified that treatment. We followed the trend by assuming that doctors' starting pay would be at least $5,000 or more higher each year than the prior year.

Now there is evidence of an opposite trend. Despite continuing inflation, new physicians' starting salaries have not increased particularly over the past couple of years. Offers ranging from $30,000 in primary care to $50,000 in various specialties appeared normal in 1978 and again in 1979.

These seem to be reasonable offers for July, 1980 hirings. We wonder if they may continue to be nearly stable into 1981. Salary levels that do not increase by at least 10 percent per year over the several years involved, indeed are lower in terms of real dollars.

The trend which we notice among small medical practices also has been observed at the large, multispecialty clinic level. In 1979, *Medical Economics* surveyed clinic administrators and found that recruiting well-qualified new physicians was becoming both easier and less costly.[2] Our experiences with large clinic clients are the same.

Although medical practice decisions must be "economic," just like those of any other business, hiring physicians are not necessarily being selfish in holding down their salary offers. Today, more doctors of the same specialty are "competing" for the same patient base. We see a bona fide uncertainty among existing practices as to whether they can expand rapidly enough to afford additional doctor salaries.

In effect, even a busy senior doctor now worries whether he can maintain his own income and pay $50,000 or more (including increased expenses) to support an associate. As inflation ravages his household and his children's tuitions, the senior doctor understandably resists offering more starting salary than absolutely necessary.

*The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.*

On the other side, the young doctors are finding fewer opportunities to start practices "from scratch" and become highly paid in just a few years. More of them are seeking to join good existing practices at the same time as the seniors are pulling back. A classic example of the law of supply and demand is at work, and it will undoubtedly continue to squeeze young doctors.

One of our employment features may become more useful in view of these circumstances. A senior doctor (or a group of them) unsure whether he can afford a new associate might lower the basic starting salary, thereby reducing the financial risk. In turn, he may promise additional pay once he breaks even financially on the new doctor's involvement — perhaps by paying "incentive compensation" geared to practice gross or net income over the agreed break-even figure. In this manner the senior(s) will have some insulation against risk, while the new doctor will be assured of a better income if he can carry his cost.

The increasing doctor supply also makes "restrictive covenants" much more important to the hiring doctors or groups. Physicians have disdained them in the past as being unnecessary since there were more than enough patients to serve with or without a new doctor's competition.

Now there is concern that an associate who leaves after one year could siphon away some of the practice and that the seniors could not recoup the loss. The senior doctors may be leery of staking a potential competitor as he develops his patients and referrals at his employer's expense. Requiring a promise not to enter competitive practice at the end of the employment, which is enforceable if reasonably drafted, is becoming an important by-product of the changing economics.

**Purchase, sale of practice**

The supply-demand factors clearly make successful medical practices increasingly valuable. The physician-owner of a practice can earn considerable income, while others cannot start comparably successful work.

In turn, young doctors may prefer to purchase existing practices. Seniors then realize that they can sell their practices just like any other items of property. To the extent the purchase price exceeds the value of the physical facilities, it is paid for "goodwill."

In the years of physician scarcity, there was little or no goodwill value to most types of medical practices. We had testified in various courts of law, after considerable survey and research, that many specialties had no goodwill — no one would have "purchased" the practices involved. Young doctors just as easily could have started their own successful offices or joined groups eager for top-flight help; in effect, there was no market.

Even when goodwill value was recognized, the figures were moderate. Many consultants used 20 percent of a year's gross income or 33⅓ percent of a year's net income as starting points for such valuations.

Now such guidelines are meaningless. Doctors planning to retire have in various specialties asked for prices equal to 100 percent of their practices' annual net income. In a few recent cases the figures have been one year's gross income. Accounting practices have "sold" for one year's gross income over the years, leading us to question whether such medical practice offers were suggested realistically or on the strength of accountants' uncritical and traditional experiences.

Young doctors have at least seriously considered accepting these offers, even though the figures have been refused or negotiated downward.

We no longer feel confident that a practice's goodwill value can be determined reliably. The times seem to be changing so fast on this issue that our advice to senior (selling) doctors is guarded: suggest a considerable price, approaching or even exceeding one year's net income depending on all the circumstances, and then be prepared to hold fast or negotiate downward depending on the young (buying) doctors' responses.

Our advice to the young physician is similarly indecisive: consider how much you really want to practice in the subject area, how good (or slim) your chances are of doing so other than by purchase, how likely other doctors might be to bid on the same practice, etc. You may agree to a high goodwill value for the opportunity to take over a mature practice, paying the price over a period of years; or you can reject it and go elsewhere.

The uncertainty over goodwill has led us to recommend a modification designed to help both sides achieve a fair result. The high value suggested by the senior physician may be reasonable when the practice produces an agreed level of income for the "buyer."

When the practice is less productive for the successor doctor then the purchase price may have been too high. The sale price may be payable over a number of years with a proviso that any annual payment will be reduced or deferred if the continuing practice's gross income falls short of agreed levels. While such an arrangement requires safeguards for the selling doctor, it might offer the young doctor enough assurance to go ahead.

We recognize that the concept of "selling" a medical practice is repugnant to the profession's ideals. A physician undertakes to care for his patients as best serves their needs; transferring them to another doctor for a purchase price may contradict that principle. Nevertheless, the economic reality cannot be ignored.

Young doctors need to find ways to enter practice to use their training and skills profitably. Senior doctors have patient relations which they can pass on to well-qualified successors. Practices thus are being bought and sold increasingly. This trend will continue to grow as the doctor surplus develops.

**Promotion to equal partnership**

Since practices have increasing goodwill values for outright purchase, it stands to reason that the same factors deserve recognition when newly hired associates are taken into partnership or corporate co-shareholder. We consider the underlying economics for corporations the same as for partnerships. For convenience, this article will not differentiate between partnership and professional corporation status.

A senior doctor who doubts whether his practice can afford a first-year associate's salary will be even more concerned whether it can thereafter double in scope to support an equal income-sharing partner. This fear is merely an added manifestation of the basic concern over the growing doctor supply.

Until recently, a senior physician (or group) tended to promote his associate to equal income parity quickly. The standard arrangement had been to provide the new partner with 60 percent of a full income share in his first year (his second year with the practice, following a year's employment), then 80 percent in the second year and full parity thereafter. The senior partner(s) rarely experienced any drop in actual incomes during these years.

Now, however, we see a moderation in this willingness to promote quickly.

More young doctors are being told that they will reach equal income rights over five years instead of three. The seniors are concerned that their practices may take that long to increase their volumes proportionately. As a result, a new member might now receive 60 percent of a full share in his first partnership year, then 70, 80, 90 and finally equal rights in the fifth such year.

Other arrangements are beginning to take a different approach. Senior doctors are sometimes conditioning the new members' shares upon practice growth sufficient to carry the increasing shares. For example, one high-income specialist took his associate into partnership at a 30 percent share of income, but the young doctor's share would not increase to 40 percent or thereafter to 50 percent until and unless certain agreed practice net income figures were reached. Especially since those target figures increase yearly to recognize inflation, we are not sure whether the young partner will ever reach full parity.

Such arrangements are not necessarily unfair to incoming partners. A senior doctor who has built a successful practice and created a certain income flow may well deserve to continue enjoying it — assuming he continues to give it his full time and attention. Conversely, even if a doctor fresh out of training is capable, it is questionable that he has a "right" to a high income if he cannot attract enough patients by his own devices. In effect again, the increasing doctor supply may thus be creating an income sharing differential to recognize goodwill.

Some people propose that the goodwill item be recognized directly. They would require an incoming partner to pay a substantial lump sum purchase price for partnership. Although this approach has some logic (i.e., if a doctor may sell his entire practice for a price, he may sell half of it to his new partner), usually we do not agree.

We consider goodwill an opportunity to earn continued income which in fact should provide income, even though taxable, to the continuing partner(s). This approach is not particularly undesirable to a senior doctor especially if his higher income carries with it tax-free deflection into a retirement plan for his benefit. And it would permit the new doctor's payment of a purchase price to be tax deductible, which would help him avoid an especially onerous burden. The goodwill element should be recognized by both members so they can proceed to work together in mutual respect and professional confidence despite economics.

### Pay to departing partners

Group practices that are costly to join should be comparably more valuable when members die, retire, or otherwise withdraw. We are beginning to advise many of our clients to reconsider their partnership termination provisions in light of changing economics.

Most partnership or group corporation arrangements have over the past ten to twenty years been rather stingy in paying departing members. They have recognized that a partner's death or withdrawal may leave the ongoing partners with a crushing patient load or else with a new doctor rapidly receiving the same equal income share.

As a result, the pay-out typically was limited to his share of the outstanding accounts receivable, often equated to two or three additional months' pay, plus return of "capital interest" in his partnership or the "book value" of his professional corporation stock.

We are observing and recommending increases in many such distributions. As an example, the group which previously provided only three months' extra pay for a retired or deceased member might amend its agreement to provide six or nine months' extra pay. The increase, no matter how categorized in the partnership agreement or corporate employment contract, is really a distribution for the goodwill value the departing member will leave behind.

Increasing the termination pay-out may be justified on paper, but the ongoing partners naturally will question whether they can afford it. In our sense of priorities, the ongoing practice must be protected. Supporting a departed partner must be secondary to that need. A good approach is to spread the distributions over several years; the ongoing group's monthly pay-out would thus be reduced while the remaining (lesser) income might be paid to a young doctor coming in as a replacement.

Above all, the increasing goodwill value does not justify securing the pay-out with life insurance. Insurance fails to provide the required funds except upon a partner's death, and yet the value should exist whether a member dies or quits.

When goodwill value exists, the practice should be able to provide income enough to pay out a departing member. A group that doubts such capacity probably has no goodwill value. Life insurance should not becloud those underlying economic realities, especially since it requires costly premium payments.

Finally, the goodwill concept makes it important to consider what will happen should a partner withdraw and open a practice in the same service area. Although groups usually recognize a member's right to leave and practice competitively, logically there should be a reduction in his termination pay-out.

In effect, a competing ex-partner will probably have taken a portion of his old group's goodwill value with him in the form of patient contacts and referrals, so he should not also be paid for it. In this case we suggest that the separation pay be reduced to its accounts receivable equivalent, perhaps two or three months' pay, or eliminated altogether if a withdrawing member chooses to compete.

### Conclusion

Despite some arguments to the contrary, medical practices are subject to the laws of supply and demand just as other businesses. The dramatic infusion of medical school graduates and foreign doctors over the past ten years, responding to a perceived shortage of physicians, now is beginning to create a doctor surplus.

Changes in inter-doctor economic arrangements are resulting. We expect the economic realities to continue increasing the importance of a practice's goodwill value.

### REFERENCES


1. See "Will surplus of MDs be good for patients? Look at San Francisco," *The Wall Street Journal*, March 13, 1980, p. 1.
2. See "Group practice jobs: Suddenly it's a buyer's market," Harry T. Paxton, *Medical Economics*, November 20, 1979, p. 27–34.

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# Modern treatment of intracranial aneurysms

**Eddy Garrido, MD**

A ruptured intracranial aneurysm is a serious condition associated with high mortality and morbidity. The natural history of ruptured aneurysms is such that 43 percent of patients die from the first hemorrhage and 35 percent from a recurrent hemorrhage in the first year, chiefly in the first three weeks after the initial bleeding.

The long term prognosis for the patient with an untreated "healed" aneurysm is also poor. The threat of hemorrhage and death persists indefinitely, with a re-bleeding rate of 3 percent per year and a mortality of 2 percent per year.[1,2]

Recent advances in the neurosurgical care of these patients, particularly the preoperative medical management and the use of the surgical microscope to obliterate the aneurysm, have decreased mortality and morbidity. A patient in good neurological condition (Grades I and II) with a ruptured aneurysm now is operable with a combined mortality and morbidity of less than 5 percent.[3,4]

**Preoperative management**

Most neurosurgeons prefer to wait at least one week from the time of the hemorrhage to operate upon the patient with a ruptured aneurysm. Generally surgical results are better when surgery is delayed. While the patient awaits surgery, there is always the threat of another hemorrhage which could be fatal. The following measures may prevent a repeated hemorrhage, as well as prevent and treat other problems associated with a ruptured aneurysm.

1. *Sedation.* The patient is kept in the neurosurgical intensive care area under heavy sedation. He should be awakened only for recording of vital signs and meals. A drug combination of Demerol and Thorazine has proved valuable for this purpose.

2. *Hypotension.* This is an important step to prevent re-bleeding. We aim to maintain the systolic blood pressure around 100mm Hg. Several medications are available for this purpose; we use a combination of Aldomet and Apresoline. In cases where there is no response to these drugs, it is necessary to use Propranolol.

3. *Antifibrinolysis.* Amicar (epsilon-amino-caproic acid) has proved effective in preventing clot lysis in vitro and in vivo. Its use in aneurysm patients has decreased the re-bleeding rate significantly.[5,6] We use 36 grams daily, given by a constant intravenous infusion.

4. *Increased intracranial pressure control.* Most patients with a ruptured aneurysm have raised intracranial pressure (ICP) in the acute stage. Cerebral edema, subarachnoid blood, hydrocephalus and intracranial hematomas may be the responsible factors, alone or in combination. Each of these problems needs to be dealt with individually. Most patients with a ruptured aneurysm are placed on steroids to control cerebral edema and occasionally it is necessary to monitor the ICP with a subarachnoid screw or a ventriculostomy catheter, to guide the medical management.

5. *Cerebrovascular spasm—prevention and treatment.* Cerebral vasospasm following aneurysm rupture occurs in 25–40 percent of patients; it could lead to cerebral infarction and death. Reserpine 0.2mg QID subcutaneously and Kanamycin 1gm TID orally have been shown to decrease the incidence of vasospasm in subarachnoid hemorrhage cases.[7] No available treatment effectively reverses a spasm once it has occurred. Measures directed to improve the cerebral circulation such as volume expansion with plasma and blood transfusions and elevation of systemic blood pressure have appeared beneficial in a limited number of patients.[8]

*Figure 1A.* Left middle cerebral artery aneurysm

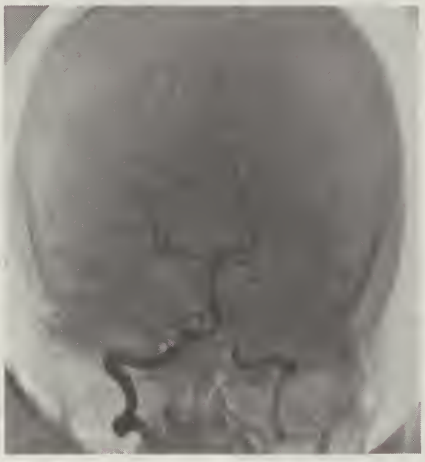

*Figure 1B.* Upper basilar artery aneurysm pointing to the left

*Dr. Garrido is assistant professor in the neurosurgery department at Temple University Hospital.*

6. *Seizure prevention.* Ten to 15 percent of patients with a ruptured aneurysm will develop seizures. Phenobarbital and/or Dilantin are used in all patients to prevent convulsions which may aggravate an already seriously ill patient.

### Surgical aspects

The ideal treatment is obliterating the aneurysm with a clip or ligature. When technical reasons prevent doing this, the aneurysm should be wrapped with gauze or plastic material. The surgical procedure is facilitated by: 1) intraoperative deep hypotension to bring the mean arterial pressure to 40–50mm Hg while the dissection and clipping of the aneurysm are carried out; 2) dehydrating agents (Mannitol, Lasix) and CSF drainage to assure a slack brain easy to retract; 3) the surgical microscope and microinstruments for a safer, better exposure and clipping of the aneurysm.

At Temple University Hospital we operated upon 18 patients with 22 aneurysms over a previous eighteen month period. There has been no mortality or lasting morbidity. Three patients developed transient third cranial nerve palsy following upper basilar aneurysm surgery and two patients had a transient confusional state following surgery. Table I gives the location of the aneurysm and the surgical procedure used. Multiple aneurysms can often be clipped during one operation (Fig. 1A, 1B, 2A, 2B).

***Figure 2A.*** **Heifetz clip obliterating the middle cerebral aneurysm**

***Figure 2B.*** **Heifetz clip obliterating the basilar aneurysm**

### Summary

Modern treatment of patients with ruptured intracranial aneurysms has decreased the mortality and morbidity associated with this lesion. A team approach to these patients by medical personnel (neurosurgeon, neurological nurses, neuroanesthesiologist) acutely aware of the problems related to intracranial aneurysms is of utmost importance for a successful outcome. □

**TABLE I**
**Aneurysm Location and Surgical Treatment***

| *Artery* | *Clip* | *Wrap* |
|---|---|---|
| Middle cerebral | 3 | 1 |
| Posterior communicating | 5 | |
| Anterior communicating | 3 | |
| Ophthalmic | 2 | |
| Anterior choroidal | 1 | |
| Internal carotid bifurcation | 2 | |
| Upper basilar | 3 | 1 |
| Vertebral | 1 | |

**Since the paper has been submitted for publication, another 11 aneurysms have been clipped without mortality or lasting morbidity.*

### REFERENCES

1. **Jane, J.A., Winn, H.R., Richardson, A.E.:** The natural history of intracranial aneurysms: re-bleeding rates during the acute and long term period and implication for surgical management in *Clinical Neurosurgery.* Williams and Wilkins, Baltimore, 1977, pp. 176–184.
2. **Pakarinen, S.:** Incidence, etiology and prognosis of primary subarachnoid hemorrhage. *Acta Neurol Scand 43:*Suppl. 29:1–128, 1967.
3. **Rand, R.W.:** Microneurosurgery in cerebral aneurysms in *Microneurosurgery.* Second edition. C.V. Mosby Co., Saint Louis, 1978, pp. 311–324.
4. **Yasargil, M.G., and Fox, J.L.:** The microsurgical approach to intracranial aneurysms. *Surg Neurol 3:*7–14, 1975.
5. **Mullen, S.:** The initial medical management of ruptured intracranial aneurysms in *Current Controversies in Neurosurgery.* Edited by Morley, T.P. W.B. Saunders Company, Philadelphia, 1976, pp. 259–269.
6. **Nebbelink, D.W., Torner, J.C., Henderson, W.G.:** Antihypertensive and antifibrinolytic therapy following subarachnoid hemorrhage from ruptured intracranial aneurysms in *Cerebrovascular Diseases,* Ninth Princeton Conference. Edited by Whisnant, J.P. and Sandok, B.A. Grune and Statton, New York, 1975.
7. **Zervas, N.T., Heros, R.C., and Lavyne, M.H.:** Frequency and reduction of infarction in stable aneurysm patients awaiting operation. Paper presented at Annual Meeting of American Association Neurological Surgeons. Toronto, Canada, 1977.
8. **Kosnik, E.J., Hunt, W.E.:** Postoperative hypertension in the management of patients with intracranial aneurysms. *J Neurosurg 45:*148–154, 1976.

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# physicians in the news

**Philip M. Gottlieb, MD,** Philadelphia, has been elected a director of the American Board of Allergy and Immunology, a conjoint board of the American Board of Internal Medicine and the American Board of Pediatrics. He is chairman of the drafting committee of the Allergy and Immunology Self-Assessment Program 1980.

**Arthur H. Hayes, Jr., MD,** has been named president of the American Society for Clinical Pharmacology and Therapeutics. Dr. Hayes is chief of the clinical pharmacology division at Hershey Medical Center.

The board of directors of Bryn Mawr Hospital has named **F. Thomas Hopkins, MD,** chief of cardiovascular service. Dr. Hopkins is clinical assistant professor of medicine at the University of Pennsylvania.

**Leon Reidenberg, MD,** was elected president of the United Cerebral Palsy of Reading and Berks County. He is a physician at the Community General Hospital.

**David Chamovitz, MD,** has been selected by the Greater Aliquippa Area Chamber of Commerce for its Brotherhood Award. Dr. Chamovitz is director of Aliquippa Hospital's cardiac care unit, cardiac laboratory, and nuclear medicine department.

**Stephen I. Rosenthal, MD,** retired from his medical practice in Scranton last August but continued to be involved with pediatrics. Dr. Rosenthal spent two months in Belize, the former British Honduras, where he treated sick and undernourished children.

The International Biographical Centre, Cambridge, England, recently selected **Basil M. RuDusky, MD,** to receive its man of achievement award. Dr. RuDusky, a Wilkes-Barre specialist in internal medicine and cardiovascular disease, also is a past recipient of the honor achievement award of the American College of Angiology and the Purdue Frederick Company.

Henry H. Fetterman, MD, Second District Councilor and Trustee, left, presents PMS 50-Year Award to Lancess McKnight, MD, member of the Delaware County Medical Society. The ceremony was part of the society's annual dinner at Llanerch Country Club.

**Charles E. Hartford, MD,** director of the Burn Treatment Center at Crozer-Chester Medical Center, has been elected president of the American Burn Association.

Two Pennsylvania cardiovascular specialists have been elected to three-year terms on the board of governors of the 10,000-member American College of Cardiology. **Harry Goldberg, MD,** Philadelphia, is the Pennsylvania (Eastern) governor and **J.R. Zuberbuhler, MD,** Pittsburgh, is the Pennsylvania (Western).

**J. Sanford Schwartz, MD,** assistant professor of medicine at the University of Pennsylvania and a member of the general medicine section at the Hospital of the University of Pennsylvania, has received a three year, $30,000 award as a W.K. Kellogg Foundation National Fellow. He will be studying technologies developed in nonhealth disciplines and determining how physicians could use these technologies.

**Henry N. Aurandt, MD,** Berks County obstetrician gynecologist, has overseen the labor and now will guide the developmental stages of a newborn television station. WTVE, Channel 51, a dream of Dr. Aurandt, became the first Reading-oriented station to cover the Lehigh Valley area.

The Health Services Agency board of directors has elected **George Davis, MD,** as a member. Dr. Davis, of Kingston, is the chief of staff at Nesbitt Memorial Hospital. He serves on the hospital's board of policy and curriculum committee and is a member of the Northern Luzerne County Area Health Council.

**Arnold Sokol, DO,** has been elected chairman of District 10 of the Pennsylvania Osteopathic Medical Association. Dr. Sokol is chairman of the general practice department and director of the cancer screening program at Suburban General Hospital, Norristown.

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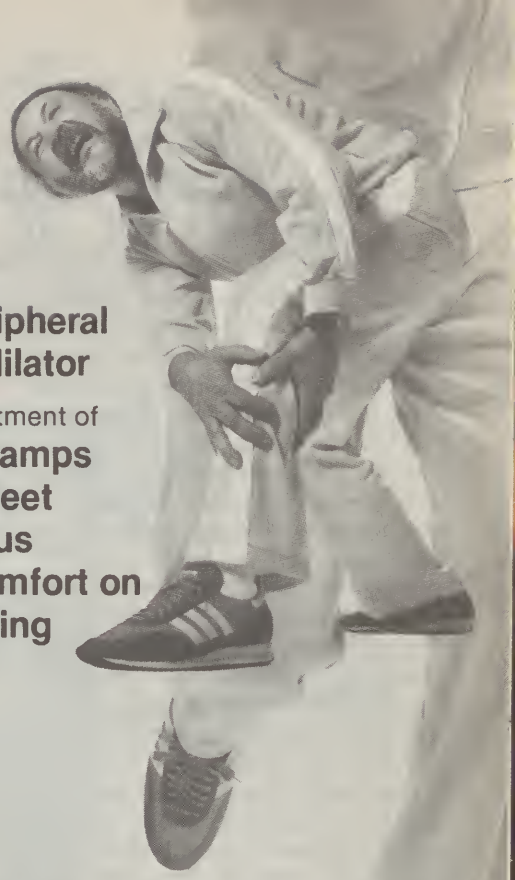

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# Court upholds right to privacy in abortion matters

**Fred Speaker, Esq.**

A Right-to-Life group, acting under the guise of an abortion clinic, had best be careful in its operations or it may face the payment of damages. In a recent decision[1] by the President Judge of the Philadelphia Court of Common Pleas, the Right-to-Life group and an abortion clinic were held to be potentially liable for outrageous conduct, invasion of privacy, and breach of confidentiality.

The action was initiated when a pregnant woman who wanted an abortion called the clinic. Speaking to an unidentified woman, the pregnant woman gave her name and address, and requested that her parents not be told about her pregnancy.

That night, two women who were agents of both defendants told the woman's parents and also a priest at her church that she was pregnant. This action embarrassed and humiliated the woman and caused her emotional distress and physical harm.

The defendants entered preliminary objections to the plaintiff's claims, which included violation of a section of the Restatement of Torts:

> One who by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another is subject to liability for such emotional distress, and if bodily harm to the other results from it, for such bodily harm.[2]

The Court, using a double negative, ruled that "it cannot be said without doubt that Defendants' conduct could not be reasonably regarded as extreme and outrageous."[3]

Turning to the charge that the defendants had invaded the plaintiff's privacy, the Court recognized that there were in fact four separate torts: "intrusion upon seclusion; appropriation of name or likeness; publicity given to private life; and publicity placing a person in false light."[4] The Court found no unlawful publication involved in the case but, using another double negative, it found that:

> Plaintiff's act of phoning would not act as a carte blanche to Defendants to reveal the fact of Plaintiff's pregnancy to her parents, especially in light of Plaintiff's specific request for confidentiality. In addition, Plaintiff has alleged that Defendants' visit to her residence was itself an intrusion. Considering all of these factors, it cannot be said without doubt that no intrusion occurred.[5]

The third charge, wrongful breach of confidentiality, brought the Court's attention to a matter relevant to physicians. The plaintiff charged that, because they held themselves out as an abortion clinic, the defendants owed her the duty of treating information about her with the confidentiality customarily accorded to medical records. Referring to a statutory provision[6] to this effect, the Court stated:

> If Defendants were actually an abortion clinic, they would clearly be subject to the duty of confidentiality "customarily accorded to medical records." Where an organization by falsely holding itself out to the public as such a clinic obtains information sought to be protected by the act, no less of a duty should attach. Accordingly, taking Plaintiff's pleaded facts as true, Defendants owed her the duty of confidentiality "customarily accorded to medical records."[7]

Having reached this conclusion, the Court faced the question of what confidentiality was customarily afforded. Here the Court once again confronted the recent Supreme Court decision in the *In Re "B"* or *Roth*[8] case. The Court reviewed the plurality opinion in that case and with a third concluding double negative found that:

> Thus, at least with respect to psychologist-patient communications, there is recognized a constitutionally protected right against disclosure. Although *In Re B* was concerned with the rights of a juvenile prisoner, its application would seem to be justified in any case in which a constitutionally recognized zone of privacy, such as procreation, is at issue, especially in light of 35 Pa.C.S.A. 6606(d).
>
> Based on these authorities it is not clear that Defendants did not owe a duty of confidentiality to Plaintiff.[9]

The *Bonacci* case, unlike others reviewed in previous issues of PENNSYLVANIA MEDICINE, expands the decision in the *Roth* case to include the right of privacy in abortion matters.

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**An article published in the May 1980, issue of PENNSYLVANIA MEDICINE contained a quotation from a court opinion which, because of an error in the manuscript, inadvertently omitted a phrase. The error appears in the article, "Court disallows negligent informed consent pleas," on page 16. The quotation below is correct; the omitted phrase is in italics.**

**"The Plaintiff's theory that a failure by the doctor to have possessed knowledge of the appropriate risks would remove the doctrine from intentional tort and create a cause of action akin to negligent informed consent. This theory is without merit. A failure by a surgeon to maintain sufficient familiarity with the risks prevalent in his specialty *could affect his degree of competency* and thereby relate to a failure to meet the standard of care required. This is not to say, however, that the nature of an action premised upon a battery, or unlawful touching, would be transformed thereby into one based upon negligence. An informed consent action is premised upon a failure by the physician not merely to *know* of the risks involved, but a failure to *communicate* those risks to his patient. It is this failure to communicate that distinguishes the causes of action."**

---

*1./ Bonacci v. Save Our Unborn Lives, Inc., et al.*, 2 P.C.R. (Phila. 1979).

*2./* Restatement (Second) of Torts §46(1) (1965).

*3./ Bonacci v. Save Our Unborn Lives, Inc., et al., supra* at 660.

*4./ Id.* at 662, quoting *Marks v. Bell Telephone Co. of Pa.*, 460 Pa. 72, 331 A. 2d 424, 430 (1975).

*5./ Id.* at 665.

*6./* "All information and documents required by this subsection shall be treated with confidentiality customarily accorded to medical records." 35 Pa.C.S. §6606(d).

*7./ Bonacci v. Save Our Unborn Lives, Inc., et al., supra* at 666.

*8./ In Re "B", Appeal of Dr. Loren Roth*, 394 A.2d 419 (Pa. Sup. 1978).

*9./ Bonacci v. Save Our Unborn Lives, Inc. et al, supra* at 667.

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# obituaries

*• Indicates membership in the Pennsylvania Society at time of death*

• **Thomas R. Boggs, Jr.,** Narberth; University of Pennsylvania School of Medicine, 1946; age 56, died February 24, 1980. Dr. Boggs was a pediatrician and professor of pediatrics at University of Pennsylvania School of Medicine. He was head of the section on newborn pediatrics and director of nurseries at Pennsylvania Hospital.

• **Jacob Frederick Crane,** Clermont, Florida; Emory University School of Medicine, 1922; age 83, died October 9, 1979.

• **Carl Leon Danielson,** Butler; Jefferson Medical College, 1931; age 79, died February, 1980.

• **Aland C. Dent,** Fayette City; Temple University School of Medicine, 1936; age 69, died February 8, 1980. Dr. Dent was a surgeon on the staff of Mon-Valley Hospital.

• **Robert J. Dickinson,** Ridgway; Temple University School of Medicine, 1938; age 68, died February 22, 1980. Dr. Dickinson founded the Ridgway Area Psychiatric Center.

• **Adrian H. Donaghue,** Margate City, New Jersey; University of Pennsylvania School of Medicine, 1935; age 70, died February 19, 1980. Dr. Donaghue had a general practice in Philadelphia for 35 years.

• **Samuel Lee Earley,** Cherry Tree; University of Pittsburgh School of Medicine, 1928; age 77, died March 12, 1980. Dr. Earley had practiced for 50 years and since 1939 had been Cherry Tree's only doctor.

• **John Lincoln Fox,** Upper Darby; Jefferson Medical College, 1943; age 62, died March 29, 1980.

• **Donald Anthony Fusia, Sr.,** Aurora, New York; University of Pittsburgh School of Medicine, 1923; age 86, died March 31, 1980.

• **Ralston Ozias Gettemy,** New Wilmington; University of Pennsylvania School of Medicine, 1917; age 91, died February 26, 1980. Dr. Gettamy had practiced internal medicine in Altoona for 57 years. He had been president of the Tuberculosis and Respiratory Disease Association for 26 years and also had served as its director.

• **Saul Greizman,** Torrance; Vanderbilt University School of Medicine, 1934; age 72, died March 28, 1980. Dr. Greizman, a psychiatrist, was medical director of Torrance State Hospital.

• **Van Buren Osler Hammett,** Bala Cynwyd; University of Pennsylvania School of Medicine, 1934; age 71, died February 24, 1980. Dr. Hammett had been chairman of the psychiatry department at Hahnemann Medical College for 16 years and past president of the Philadelphia Psychiatric Society.

• **John W.G. Hannon,** Washington; Jefferson Medical College, 1927; age 79, died March 1, 1980. Dr. Hannon was medical director of Jessop Steel Company and McIntyre Research Foundation in Toronto. He pioneered the use of aluminum powder in controlling silicosis and was an industrial medicine consultant for ceramic, coal, foundry, gold, and uranium industries in the U.S. and Canada.

• **Reeves Frederick Jones,** Stroudsburg; Temple University School of Medicine, 1938; age 68, died February 3, 1980. Dr. Jones was a member of the staff at Pocono Hospital and school doctor for the East Stroudsburg school district.

• **Gail W. Kahle,** Marienville; College of Physicians and Surgeons of Baltimore, 1910; age 96, died March 12, 1980. Dr. Kahle practiced in the Greenville-Hadley area of Mercer County for 37 years. He moved to the Marienville-Vowinckel area to retire but instead established another practice which he continued until his death.

• **Jacob Kincov,** Easton; State University of New York, Down State Medical College, 1929; age 74, died March 23, 1980. Dr. Kincov, an Easton physician for 44 years, was chief of medical service at Easton Hospital from 1946 until 1964 when he retired.

• **Howard Dale Kuhns,** California; University of Pittsburgh School of Medicine, 1934; age 72, died March 25, 1980. Dr. Kuhns served as college physician for California State College and was a member of the staff at Brownsville General Hospital.

• **Joseph Albert Ladika,** Reading; Jefferson Medical College, 1954; age 58, died March 4, 1980. Dr. Ladika was a neurologist at St. Joseph Hospital.

• **Melvern M. Mackall,** Forty-Fort; Western Reserve University School of Medicine, 1911; age 95, died January 28, 1980. Dr. Mackall was a practicing physician in Beaver County for more than 30 years.

• **Hans Joseph Mezger,** Philadelphia; Ludwig Maximilians University, 1921; age 83, died November 16, 1979.

• **Hamil Ralph Pezzuti,** Camp Hill; Jefferson Medical College, 1933; age 72, died March 16, 1980. Dr. Pezzuti was a retired chief surgeon of Harrisburg Hospital, and a former chairman of the surgery department.

• **Warren Charles Phillips,** Camp Hill; Jefferson Medical College, 1934; age 70, March 18, 1980. Dr. Phillips was an ophthalmologist in Harrisburg for 35 years.

• **Lloyd C. Piersol,** Lancaster; Hahnemann Medical College, 1931; age 75, died February 14, 1980. Dr. Piersol was a staff physician in the obstetrics department at St. Joseph Hospital and was former chief of the state tuberculosis clinic.

• **William A. Prideaux, Jr.,** Claysville; University of Pennsylvania School of Medicine, 1932; age 73, died February 25, 1980. Dr. Prideaux served as the McGuffey school district physician and as a consulting physician to community nursing homes.

• **John Keim Rothermel,** Strausstown; Jefferson Medical College, 1932; age 73, died March 10, 1980. Dr. Rothermel had practiced in Strausstown for 35 years.

• **Caesar F. Sarni,** Pottstown; Hahnemann Medical College, 1933; age 74, died February 19, 1980. Dr. Sarni, a general surgeon, served on the staffs of Pottstown and Memorial hospitals.

• **Donald B. Stouffer,** Camp Hill; University of Michigan School of Medicine, 1925; age 80, died March 20, 1980. Dr. Stouffer was a retired orthopedic surgeon.

• **Raymond C. Truex,** Oreland; Temple University School of Medicine, 1967; age 68, died February 6, 1980. Dr. Truex was professor emeritus of anatomy at Temple University School of Medicine and author of *Human Neuroanatomy.*

• **Clarence Weston Waring,** Sarver; Hahnemann Medical College, 1924; age 83, died March 18, 1980. Dr. Waring had been with the Veterans Administration in Pittsburgh.

• **Floyd Glenn Wood,** Cochranton; Western Reserve University School of Medicine, 1927; age 78, died February 19, 1980. Dr. Wood had practiced in Cochranton for 43 years.

• **Newton A. Wyman,** Swarthmore; Temple University School of Medicine, 1932; age 78, died March 3, 1980. Dr. Wyman had been chief of surgery at Chester Hospital.

• **Ralph Joseph Zecca,** Philadelphia; Hahnemann Medical College, 1954; age 51, died February 8, 1980. Dr. Zecca was chairman of the internal medicine department at Nazareth Hospital.

**Dante J. Bevilacqua, Sr.,** Philadelphia; Hahnemann Medical College, 1931; age 75, died March 28, 1980.

**David F. Hottenstein,** Kutztown; Hahnemann Medical College, 1937; age 73, died February 2, 1980.

**David M. Kamsler,** Baltimore, Maryland; Jefferson Medical College, 1975; age 32, died March 1, 1980.

**Gerald Edward Koncle,** Newmanstown; University of Pittsburgh School of Medicine, 1931; age 74, died March 24, 1980. Dr. Koncle was a general practitioner in Brodheadsville from 1935 until 1948 when he moved his practice to Newmanstown where he worked for 32 years.

**William J. Mellman,** Philadelphia; University of Pennsylvania School of Medicine, 1952; age 51, died February 26, 1980. Dr. Mellman was chairman and professor of the department of human genetics at the University of Pennsylvania School of Medicine. He also was director of the university's Human Genetics Center.

**John S. Solhaug,** Pittsburgh; University of Minnesota School of Medicine, 1950; age 58, died March 13, 1980. Dr. Solhaug was the assistant superintendent of Woodville State Hospital.

**Charles Irvin Stoner,** Altoona; University of Texas School of Medicine, 1929; age 78, died February 17, 1980. Dr. Stoner was an obstetrician and gynecologist at Mercy and Tyrone hospitals.


# EMERGENCIES IN CLINICAL MEDICINE

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# in my opinion

## Physician assistant rules well conceived guidelines

Physicians have used self-styled physician assistants and nurse practitioners in their offices for years. It has not been uncommon for family physicians, as well as other primary care physicians, to have a heterogeneous group of office personnel to assist them.

Such personnel may take blood pressures, counsel patients about their disease and medication, or do procedures such as pap smears, partial vaginal examinations, and history-taking. Physician assistants and nurse practitioners also have been used in specialized settings.

No matter what the tag, these people with varied backgrounds were serving as physician assistants or nurse practitioners. With the current mandates for meeting a basic standard of care, it is inevitable that minimum training standards and certification would be required.

Adding to the above was the shortage of physicians, especially in rural areas, that became obvious in the 1950s and 1960s. The federal government attempted to compensate for these shortages by capitation grants. As a result, the number of physicians graduating each year from American medical schools has doubled since 1960.

Simultaneously, many medical schools and other institutions developed training programs for physician assistants and nurse practitioners who would do routine medical care procedures that the physician normally would do. Such activities would be done under the direct surveillance of the physician.

*The physician assistant by concept has become and must serve as a direct extension of the individual physician and his medical care activities.* Only those procedures should be delegated to the physician assistant that could be carried out with equal competence as when done by the physician himself and would include only those daily activities of the physician that require less training.

With the above on line, i.e., the physician's need for technical assistance in his practice and the academic institutions training physician assistants and nurse practitioners to deliver these services, we now have developed a basic cadre of health care associates known as physician assistants and nurse practitioners. Act 79 of 1979 amended the Medical Practice Act to recognize physician assistants and provide regulation of their activities.

Act 79 assigns to the Board of Medical Education and Licensure the responsibility of establishing and certifying a minimum standard of care that must be achieved by physician assistants in their activities as providers of a clearly defined health care service. The American Medical Association evaluates and approves the training programs.

The law states that the physician assistant is always the extender of services of an individual physician and *not* an institution, a multispecialty group practice, or even a group of physicians in a hospital department or polyclinic. It is that individual physician (or his designee in his absence) who assumes professional and medicolegal responsibility for the acts of his physician assistant.

Deliberations of various medical society and state committees involving physician assistants and their activities indicate that many institutions and their medical staffs do not understand these basic concepts. Such institutions and staffs appoint physician assistants in the capacity of what amounts to a rotating internship.

Assistants do admission histories and physicals on all types of patients, but are responsible not to a specific physician but rather to a group or even an entire hospital staff. This is contrary to the law and the regulations. A physician assistant can only be responsible to an individual physician or that physician's designee in his absence.

Act 79 and the subsequent regulations are well written. Any physician or medical administrator who plans to use physician assistants should read them carefully. As a matter of fact, the more you work with the regulations, the more obvious it becomes that they are well conceived.

The regulations help us avoid the sidetracks and difficulties that could arise when the simple concept is not followed that the physician assistant is a direct extension of the activities and responsibility of the physician who sponsors him and who assumes medicolegal, as well as professional, supervisory responsibility. This is what the physician assistant regulations are all about.

John H. Moyer, MD
Johnstown

*Dr. Moyer, senior vice president for professional and educational affairs at Conemaugh Valley Memorial Hospital, is professor of medicine at Temple University School of Medicine and clinical professor of medicine at Pennsylvania State University. He is on the Physician Assistant Advisory Committee to the Pennsylvania State Board of Medical Education and Licensure.*

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**DESCRIPTION:** Methyltestosterone is 17$\beta$-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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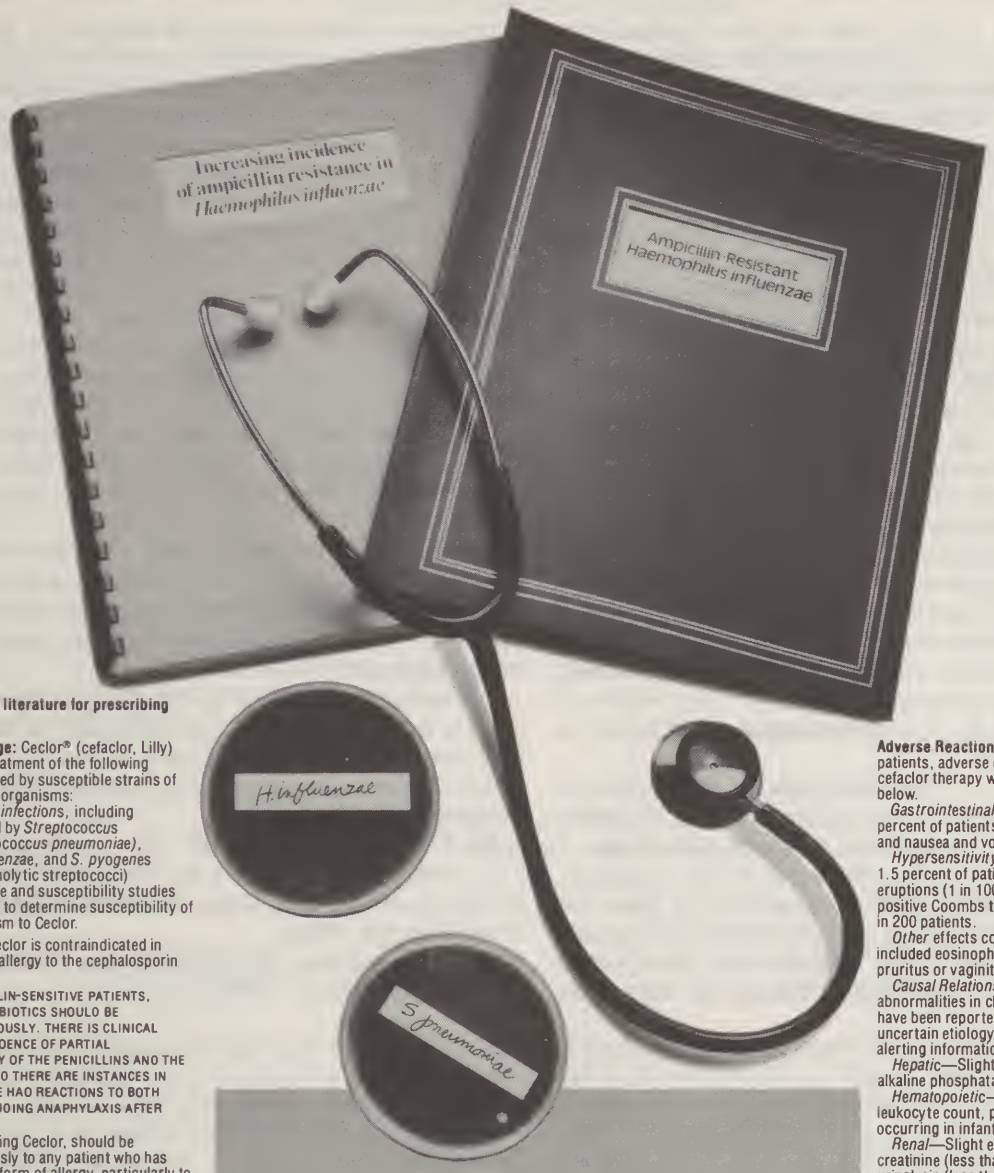
# An added complication... in the treatment of bacterial bronchitis*




**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage:** Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note:* Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**
1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.*

Lilly

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000482

## Restated Articles of Incorporation

ARTICLE I. The name of the Corporation shall be "Pennsylvania Medical Society." Said name has been registered with the Department of State of the Commonwealth of Pennsylvania within six months of the date of the application for approval of these Restated Articles of Incorporation.

ARTICLE II. The registered office of the Corporation will be in Lemoyne, Cumberland County, Pennsylvania, and its address shall be 20 Erford Road, Lemoyne, Cumberland County, Pennsylvania.

ARTICLE III. The said Corporation is formed for the purpose of federating the medical profession in the Commonwealth of Pennsylvania; to unite with similar state medical societies to constitute the American Medical Association; to extend medical knowledge and to advance medical science; to elevate and maintain the standards of medical education; and to uphold the ethics and dignity of the medical profession.

ARTICLE IV. The Corporation is to have perpetual existence.

ARTICLE V. The Corporation shall have no capital stock.

ARTICLE VI. No members of the Corporation shall receive any pecuniary gain or profit, incidental or otherwise, from its activities.

ARTICLE VII. Membership in the Corporation shall be limited exclusively to persons who are members in good standing of a county medical society duly affiliated with the Corporation, and the failure on the part of any such member to keep himself or herself in good standing in such affiliated county medical society shall be sufficient cause for expelling the member from the Corporation, either by automatic termination of membership or otherwise as the Bylaws of the Corporation shall provide. Nothing herein shall be construed to prevent the Corporation from electing honorary members or special members from among persons who are not members in good standing of affiliated county medical societies.

As stated in the Restated Articles of Incorporation of the Corporation, the new corporate name as set forth therein has been duly registered with the Department of State of the Commonwealth of Pennsylvania, as evidenced by its Certificate dated November 20, 1959 ...

As provided in Section 706 of the Non-Profit Corporation Law, the Corporation has caused due notice of its intention to apply to this Honorable Court for an amendment to its charter to be advertised in two newspapers ...

In view of the foregoing, the Corporation requests this Honorable Court to issue its Order and Decree that the Restated Articles of Incorporation of the Corporation be approved as the charter of the Corporation.

IN WITNESS WHEREOF, the undersigned have hereunto set their hands and affixed the corporate seal of the Corporation this 23rd day of November, 1959.

(Secretary's Note: Approved by the Commonwealth, December 1959.)

## PROPOSED REVISION

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# Official Call to the 1980 House of Delegates

The current Constitution requires that amendments to such should be received by the Secretary at least four months prior to the annual meeting and should be published in the Official Call in the journal of this Society at least two months prior to the annual meeting.

The Committee on Constitution and Bylaws is submitting an extensive revision of the entire Constitution and Bylaws for publication in this Call. The Bylaws' provisions have been merged with the Constitution's provisions to render one set of "new" bylaws proposed to amend the current Constitution and Bylaws in their entirety. The proposed revision is accompanied by a summary, corresponding to the sections of the proposed revision, which cites the origins of provisions and explains any changes.

Ordinarily, amendments to the Constitution and Bylaws are published 60 days prior to the annual meeting. Due to the length of the proposed revision and accompanying summary, it is beneficial to publish the texts in three installments.

This installment of the Official Call includes the Call to the 1980 House of Delegates, Restated Articles of Incorporation of this Society, and the beginning of *Proposed Amendments to the Constitution and Bylaws, Subject One,* Chapters I through VIII.

The second installment of the Official Call in the July issue will include Chapters IX through XV, a continuation of *Proposed Amendments to the Constitution and Bylaws, Subject One.*

The third installment of the Official Call in the August issue will include the balance of the revision, Chapters XVI through XXII, to complete *Proposed Amendments to the Constitution and Bylaws, Subject One.* Amendments to the Constitution and Bylaws other than this proposed revision from the Committee on Constitution and Bylaws will be included as is customary. The August issue also will contain other standard items which normally appear at that time. Please note the table of contents of the proposed Revision.

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The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Fairmont Hotel, Philadelphia, Pennsylvania, on Friday, October 31, 1980. The second session will convene Saturday, November 1, 1980 and the third session Sunday, November 2, 1980. Details regarding the starting times of all three sessions will appear in the Official Call in the August 1980 issue of PENNSYLVANIA MEDICINE.

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**SUBJECT ONE: Proposed revision to amend the Constitution and Bylaws in their entirety.**

## Pennsylvania Medical Society Bylaws

### CHAPTER I
### MEMBERSHIP

**Section 1 — Rights and Privileges of Membership Including Voting Rights** — All members of this Society shall have all of the rights and privileges of membership except as otherwise provided in these bylaws.

No member of this Society of any class shall have any direct vote in the affairs of this Society except as to such matters, if any, where such vote is required by the laws of the Commonwealth of Pennsylvania.

**Section 2 — Admission to Membership** — To be a member of this Society a physician must be a member of a component society. The term, physician, means a person who has received formal and recognized training in the art and science of medicine and is qualified to acquire an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania.

Once elected to a category of membership other than Honorary, in a component society, the member is required to become a member of this Society within three months by paying any appropriate assessment and having the component society certify to the Executive Vice President of this Society that the member possesses the qualifications for the category as described in these bylaws.

## Source and Analysis

### CHAPTER I
### MEMBERSHIP

**Section 1 — Rights and Privileges of Membership Including Voting Rights** — This provision, transferred from Section 10, Article IV of the current Constitution, page 3, grants full rights and privileges to all members. The exceptions to full rights and privileges now appear in the sections describing each membership category. The paragraph which explains the direct vote of a member is transferred unchanged from Section 10, Article IV, page 3.

**Section 2 — Admission to Membership** — This is a modification of Sections 1, 2, and 3 of Chapter I of the current Bylaws, page 13. The current Section 1 defines the term, physician. The current Section 2 explains the unified state-county membership. The current Section 3 explains that certification of membership and payment of any appropriate assessment are required. This proposed section combines the essential elements of the three current sections. There is no reference to provisional member since it is not an official membership category. The definition of the term, physician, in the proposed revision is more appropriate since it conforms to the literal definition, and the definition in the Statutory Construction Act, and the Medical Practice Act.

**Section 3 — Membership Categories**

a. *Active Member* — An active member of this Society shall be a physician who is a member of a component society and is required to maintain an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania. Variations in this category are:

1.) A senior member must be 65 years of age or over (by January 1) and have been an active member of this Society, or an active member of a constituent association of the American Medical Association, for a continuous term of 30 years. A member in this category is entitled to full benefits, is required to pay only 50 percent of the annual assessment, and is required to maintain an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania.

2.) A civilian physician who does not have a license to practice medicine and surgery in the Commonwealth of Pennsylvania, but is employed by the state or federal government, may become an active member of this Society, entitled to full rights and privileges, provided the full annual assessment is paid.

3.) A commissioned medical officer of any branch of the military or its reserve, who is on extended active duty (more than four years) and who does not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania may be an active member of this Society, entitled to all rights and privileges of membership provided certification is received from the appropriate Surgeon General and the full annual assessment is paid.

4.) A physician who begins to serve a temporary military or other government service is not required to maintain an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania during the term of the service and shall be excused from payment of any assessment for any assessment year in which the member enters service prior to March 1, is in service for the entire assessment year, or returns from service on or after March 1. A member meeting these criteria of membership shall be entitled to all rights and privileges.

5.) An individual in a graduate training program may be an active member of this Society, entitled to all rights and privileges. Such a member is required to pay 10 percent of the annual assessment. The graduate training program may be a recognized residency in an accredited hospital or other full-time graduate training. This individual must have a graduate certificate from the Commonwealth of Pennsylvania or an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania.

An individual in graduate training who also begins temporary military or other government service shall be excused from payment of any assessment and shall not be required to have a graduate certificate or an unlimited license. A member meeting these criteria shall be entitled to all rights and privileges of membership.

**Section 3 — Membership Categories**

a. *Active Member* — Section 2, Article IV, page 1 of the current Constitution has been transferred to this new section with the licensing requirement specified. This new section lists the variations within categories and the qualifications necessary for each.

1.) Senior Member — Section 3, Article IV, page 2 of the current Constitution describes criteria for this membership category. This new section renames the category and deletes the reference to "AMA service member" category since it is not in use. Also deleted is the restriction which did not allow an associate to become a senior member.

2.) A Civilian Physician — Full-time Federally Employed - Section 5, Article IV, page 2 of the current Constitution describes those physicians eligible for active membership even though employed full-time by a federal agency, including the Public Health Service, or in the military service. For clarity, this new section divides the federal agency employed physicians and those in the military service. However, this new section retains the criteria for payment of dues and licensing. The reference from the current section to "Bachelor of Medicine" has not been included in the revision since it is not contemporary.

3.) A Commissioned Medical Officer - Section 5, Article IV, page 2 of the current Constitution describes the criteria for active membership for those physicians on extended active duty in the armed forces (more than two years). This new section retains the criterion for payment of assessments; however, the tour of duty to be considered "extended" is now "more than four years." See next section.

4.) Temporary Military or Government Service — The only reference to a physician serving temporarily in the military or other government service in the current Constitution is Section 1, Article XI, page 10. It describes the exemption from an assessment for an individual meeting the criteria. This new section describes temporary service as "four years or less," exempts the individual from the assessment, and provides the individual with all rights and privileges of membership.

5.) A Graduate-in-Training — Section 7, Article IV, page 2 of the current Constitution describes who is eligible for this category and refers to these individuals as "interns" or "residents." This new section retains the criteria that the graduate be in specific training and pay 10 percent of the annual assessment. The requirement that the individual have a graduate certificate or an unlimited license has been added to conform to the state licensing requirement. Hereafter, the individuals will not be referred to as interns but graduates-in-training with the understanding that resident is still usable since it is a form of graduate training. This change accommodates the various forms of physician training as prescribed by the AMA and the state licensing board.

**SPECIAL NOTE: Hereafter, reference to active members should be understood to include those variations listed in Section 3.a., 1-5 of Chapter 1 of the proposed revision.**

6.) An active member who is prevented from the practice of medicine by illness or disability shall be excused from the payment of an annual assessment during such time, providing the individual's component society grants a corresponding exemption.

b. *Associate Member* — An associate member shall be a physician who is 70 years of age or over (in the year of application) and has been an active member of this Society, or an active member of a constituent association of the American Medical Association for a continuous term of 30 years. An associate member shall not be required to pay any annual assessment and shall not be required to maintain a license.

c. *Affiliate Member* — Upon recommendation and certification in due form by the component society to and election by the Board of Trustees, any member of a component society not engaged in active practice within the jurisdiction of the component society may be an affiliate member of this Society and remain as such providing the individual is one of the following: (1) a physician who is a member of a national medical society of a foreign country; (2) an American physician who is engaged in missionary or philanthropic labors who may or may not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (3) a full-time teacher of medicine or of the arts and sciences allied to medicine who does not have a license to practice medicine and surgery in the Commonwealth of Pennsylvania; (4) a physician who is engaged in research or administrative medicine in Pennsylvania who does not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (5) a physician who is retired from active practice; (6) a physician who has moved out of Pennsylvania and concurrently maintains active membership in the state medical society and the component society of the state society in the new state of residence. Once elected by the Board of Trustees to this category, the affiliate member is not required to pay any annual assessment.

An affiliate member is not entitled to the benefits of the Medical Benevolence Fund or any similar fund of this Society. Membership in the affiliate category does not count toward accumulation of years for eligibility for Senior or Associate categories with the exception of the physician who is engaged in missionary or philanthropic labors. An out-of-state affiliate member is not eligible to participate in insurance programs endorsed by the Pennsylvania Medical Society.

An affiliate member may not vote, hold office, or serve as a member of any council, commission, or committee.

d. *Honorary Member* — A physician who is not a resident of Pennsylvania, but is a member of his own state or territorial medical association, may be elected to this category by the House of Delegates by a three-fourths vote at any annual meeting. The individual may not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania. The honorary member is not required to pay any annual assessment. No more than two honorary members may be elected in any one year to this category by the House of Delegates.

An honorary member is not entitled to any of the rights and privileges of membership.

6.) Disabled Physician — Section 1, Article XI, page 10, item (d) of the current Constitution provides for an excuse of payment of an annual assessment for a disabled or ill physician. This new section retains that provision.

b. *Associate Member* - Section 4, Article IV, page 1 of the current Constitution describes criteria for this category. This new section modifies the current section slightly by deleting the reference to the "AMA service member" category since it no longer exists.

c. *Affiliate Member* - Section 6, Article IV, page 2 of the current Constitution defines eligibility for this membership category and prescribes that the Board of Trustees must approve applications. This new section contains all those essential elements along with the addition of restrictions of membership rights and privileges from the current Section 10, Article IV, page 3 of the Constitution.

d. *Honorary Member* — Section 8, Article IV, page 3 of the current Constitution describes eligibility for this membership category. This new section contains those essential elements with the addition of the specific restriction of membership rights and privileges from the current Section 10, Article IV, page 3 of the current Constitution.

e. *Special Student Member* — A special student member shall be a president of an active chapter of the American Medical Students Association of a medical school in the Commonwealth of Pennsylvania and shall not be required to pay any annual assessment.

Each special student member shall serve as a delegate in the House of Delegates with the right to vote and to serve on any reference committee except that to which are referred bylaws amendments. A special student member is not eligible for election to office in this Society, not entitled to benefits from the Medical Benevolence or similar funds, and has no other rights and privileges not herein stated.

**Section 4 — Continuing Medical Education Requirement** — An active or associate member of this Society who maintains an unlimited license to practice medicine and surgery in the Commonwealth must qualify for the American Medical Association's Physician's Recognition Award or its equivalent and must continue to qualify for such award in order to remain a member in good standing of the Pennsylvania Medical Society. The Board of Trustees shall have the power to waive such requirements, in keeping with approved procedures, for members requesting waivers.

## CHAPTER II
## COMPONENT SOCIETIES

**Section 1 — Definition** — Component societies shall be those county medical societies organized in the Commonwealth of Pennsylvania whose purposes and bylaws are in accord with those of this Society.

**Section 2 — Affiliation of a Component Society** — A county medical society organized in the Commonwealth of Pennsylvania in a county, or in a sparsely settled area of two or more counties in which no component society exists, may apply to the Board of Trustees and Councilors of this Society to become an affiliated component society provided: (a) its purposes are generally in accord with the purposes of this Society; (b) its bylaws are approved by the Board of Trustees and not inconsistent with the bylaws of this Society; and (c) its application has been approved unanimously by the District Censors of the district in which it is located.

**Section 3 — Termination of Affiliation of a Component Society** — The affiliation of any component society may be terminated only by two-thirds vote of the House of Delegates. Reasonable evidence must be presented to the House of Delegates that (a) the bylaws of the component society are not in accord with the bylaws of this Society, or (b) that activities of the component society militate against the best interests of organized medicine or are detrimental to the profession of medicine, or (c) the component society has refused, after reasonable notice, to comply with any requirement of the bylaws of this Society.

**Section 4 — Autonomy of Component Societies** — Each component society shall have control of its own affairs and of the admission to membership therein. It shall seek to

e. *Special Student Member* — Section 9, Article IV, page 3 of the current Constitution describes eligibility for this membership category. This new section contains those essential elements with the addition of the restrictions on rights and privileges of membership from Section 10, Article IV, page 3 of the current Constitution.

**Section 4 — Continuing Medical Education Requirement** — The continuing education requirement is described in Section 12, Article IV, page 3 of the current Constitution and Section 5, Chapter I, page 13 of the current Bylaws. This new section retains the requirement that members must qualify for the Physician's Recognition Award or its equivalent and the provision for waivers according to procedures established by the Board of Trustees. The categories for waivers are deleted from this new section to permit the Board of Trustees the latitude to change these categories as circumstances require without amending the bylaws.

## CHAPTER II
## COMPONENT SOCIETIES

**Section 1 — Definition** — The definition is taken from Article III, page 1 of the current Constitution. This section requires bylaws of the component to be in accord with PMS.

**Section 2 — Affiliation of a Component Society** — Section 1, Chapter XVI, page 34 of the current Bylaws describes the process of affiliation of a component with PMS. Essentially, this new section contains the same wording.

**Section 3 — Termination of Affiliation of a Component Society** — Section 2, Chapter XVI, page 34 of the current Bylaws describes the termination of affiliation of a component. Essentially, this new section contains the same wording.

**Section 4 — Autonomy of Component Societies** — Section 9, Chapter XVI, page 36 of the current Bylaws, Direction of Affairs of Component Societies, describes the au-

improve the scientific, moral, and professional condition of every physician within its jurisdiction and shall make systematic efforts to increase membership. It shall file with the Executive Vice President a copy of amendments to its bylaws as they are adopted, or before adoption when advance approval is sought.

**Section 5 — Investigation of Applicants for Membership** — Each component society shall make a thorough investigation of applicants for all categories of membership, including a formal inquiry to the biographic department of the American Medical Association.

**Section 6 — Membership Records** — It is the duty of the secretary of each component society to maintain a roster of its members. Such roster shall include, but not be limited to, the full name, current address, medical or osteopathic school, date of graduation, date of registration, and license to practice in this state. The roster shall be filed with the office of the Executive Vice President of the Pennsylvania Medical Society. Any changes in the aforementioned information or the status of membership should be forwarded promptly to the office of the Executive Vice President of this Society.

**Section 7 — Membership Assessments** — The secretary or the treasurer of each component society shall, prior to January 1 of each year, render an annual assessment statement to each member of said component society indicating that payment of this assessment is due to this Society on January 1 or will be considered delinquent if not paid before March 1. New members shall be notified by a similar statement from the component society that the annual assessment is payable before final acceptance into membership. The secretary or treasurer of the component society shall promptly remit all assessments of this Society to the office of the Executive Vice President.

**Section 8 — Membership Transfers** — A member in good standing of any component society may transfer to another county society in Pennsylvania upon recommendation by his society for admission to membership in the component society into whose jurisdiction he moves without the delay attendant upon ordinary applications for membership.

**Section 9 — Choice of Membership** — A physician living near a county line or living in one county and maintaining an office in another county may hold membership in the component society most convenient on permission of the Trustee of the District in which he resides. No person may concurrently hold membership in more than one component society of components. This new section has been renamed and only slightly modified by directing the component to exert its influence to enhance "professional conditions" and not "economic conditions." Editing has caused other minor language changes without changing the content.

**Section 5 — Investigation of Applicants for Membership** — Section 3, Chapter XVI, page 34 of the current Bylaws requires investigation of applicants for membership. This new section retains the essential requirement which includes inquiry to the biographic department of the AMA.

**Section 6 — Membership Records** — Section 4, Chapter XVI, page 34 of the current Bylaws requires in the first paragraph the maintaining of membership records. The second paragraph of that section addresses each membership category's certification requirement. The third paragraph requires new members to pay an annual assessment at the time they become members; county societies to notify the PMS Executive Vice President of the suspension of a member in full detail; and the component society secretary to report election of officers of the component society within 15 days of the election (page 35).

The new section requires maintaining a roster of the component's members with appropriate information filed with the PMS Executive Vice President.

The requirement to notify PMS of the elections of officers has been deleted. The PMS membership department annually mails a form to each county society which is returned with the names of officers for the year. The 15 day requirement for reporting is not included since it is unenforceable.

**Section 7 — Membership Assessments** — Section 5, Chapter XVI, page 35 of the current Bylaws describes rendering of statements for assessments and remitting of assessments collected to the Executive Vice President of PMS. This new section rewords all the essential elements.

**Section 8 — Membership Transfers** — Section 7, Chapter XVI, page 35 of the current Bylaws describes how a member may transfer his membership. This new section uses the same wording.

**Section 9 — Choice of Membership** — Section 8, Chapter XVI, page 35 of the current Bylaws stipulates how a member may choose the component society. This new section uses the same wording in two sentences instead of one with minor changes as a result of editing.

nent society, except that a member who has full membership in one county medical society in Pennsylvania may be eligible to hold affiliate membership in any other county medical society in the state.

**Section 10 — Delegates to the Pennsylvania Medical Society** — Each year, each component society shall elect from its active or associate members a number of delegates and alternates to which it is entitled in the House of Delegates of this Society to serve the calendar year. The number of delegates and alternates is based on the number of the component society's active and associate members as of December 31 of the preceding year. The component society's bylaws shall contain appropriate provisions for determining the manner in which the number of the elected delegates shall increase or decrease as the case may be.

**Section 10 — Delegates to the Pennsylvania Medical Society** — Section 10, Chapter XVI, page 35 requires components to elect delegates to the PMS House of Delegates, the number allowed to be determined by the number of active and associate members in the component as of December 31 of the preceding year. This new section rewords the essential requirements and specifies that the delegates serve the calendar year. Note that the active category may consist of those variations listed in Section 3. a, 1-5, Chapter 1, of this proposed revision.

## CHAPTER III
## ASSESSMENTS

## CHAPTER III
## ASSESSMENTS

**Section 1 — Purpose** — Money for the purposes of this Society shall be raised by assessments.

**Section 1 — Purpose** — Section 1, Article XI, page 10, the first sentence of the current Constitution is transferred to this new section with reference to "assessments" instead of "annual assessments" since assessments may be annual or special.

**Section 2 — Annual Assessment** — The annual assessment is to be fixed each year by the House of Delegates at the annual meeting after opportunity has been given to the Board of Trustees to recommend the amount.

The full annual assessment is to be paid by active members of this Society. Exceptions to full payment of the annual assessment shall be as follows:

a. Senior members shall be required to pay 50 percent of the annual assessment.

b. Graduates in training shall be required to pay 10 percent of the annual assessment.

c. Active members in their first full calendar year of practice following completion of a training program shall be required to pay 50 percent of the annual assessment.

d. Members serving temporarily in the armed forces or other governmental service of the United States shall be excused for any assessment year in which the member enters service prior to March 1, is in service for the entire assessment year, or returns from service on or after March 1.

e. Any member prevented from the practice of medicine by reason of illness or disability shall be excused provided the member's component society grants a corresponding exemption from its annual assessment.

f. Associates, affiliates, special students, and honorary members shall not pay any annual assessment.

g. New members becoming such not more than six and not less than two months prior to the end of the assessment year shall pay 50 percent of the annual assessment.

h. New members becoming such not more than two months prior to the end of the assessment year shall not pay the annual assessment provided the full annual assessment for the appropriate category is paid for the following year upon joining.

**Section 2 — Annual Assessment** — Section 1, Article XI, pages 10 and 11, of the current Constitution describes who pays assessments by membership category and stipulates that the House of Delegates fixes the amount of the annual assessment after the Board of Trustees make a recommendation. This new section changes the order of the essential information but not the content.

**Section 3 — Special Assessments** — A special assess-

**Section 3 — Special Assessments** — Section 1, Chapter

ment requires the approval of the House of Delegates after hearing the Board of Trustees state the nature thereof, recommend the amount, and suggest the manner and time of payment.

**Section 4 — Payment of Assessments** — The annual assessment, which is due January 1 of the assessment year, shall be paid through the member's component society to the Executive Vice President of this Society. The annual assessment, if not paid by March 1 of the assessment year, shall be considered a delinquent assessment. A special assessment shall be paid directly to the Executive Vice President prior to the due date of any special assessment.

**Section 5 — Delinquent Assessment — Delinquent Member** — An annual or special assessment not paid by the date prescribed shall be a delinquent assessment. A delinquent assessment renders the member delinquent and such member shall not be entitled to exercise any of the rights and privileges of membership in this Society during the period of delinquency. The Executive Vice President shall send a notice to each delinquent member within 60 days of the date such member becomes delinquent, stating the amount due and requiring the member to pay the amount within 30 days after the date of the notice or be terminated automatically from membership in this Society.

**Section 6 — Assessment Year** — The calendar year shall be the assessment year for the purpose of the annual assessment of members.

**Section 7 — Other Income** — In addition to assessments as prescribed in these bylaws, funds for this Society also may be raised by voluntary contributions and in any other legal manner approved by the House of Delegates.

## CHAPTER IV
## FUNDS

**Section 1 — Special Funds** — The House of Delegates may establish special funds for educational, scientific, charitable, benevolent, endowment, medical defense, or other purposes by resolution or bylaws amendment. These may be in the form of trusts or otherwise, with trustees or managers, and under terms determined by the House. The House of Delegates may require the Board of Trustees to allocate specific portions of the annual assessments to such fund or funds. The Board of Trustees shall have the power to establish reserves and special funds, consistent with good accounting practice, and to establish and manage, or delegate to trustees or managers, the management of trusts and funds comprising monies donated or contributed to the Society.

IX, page 22 of the current Bylaws allows the House to set special assessments. This new section contains that requirement and adds that the Board of Trustees makes the recommendation for the amount of the assessment.

**Section 4 — Payment of Assessments** — Section 1, Chapter IX, page 22 of the current Bylaws describes methods of payment of assessments. This new section rewords the essential elements.

**Section 5 — Delinquent Assessment/Delinquent Member** — Section 2, Chapter IX, page 22 of the current Bylaws entitled "Delinquent Assessments" describes a delinquent member, a delinquent assessment, and the requirements for delinquency notification. This new section essentially remains unchanged but uses simpler language.

**Section 6 — Assessment Year** — Section 2, Chapter X, page 24 of the current Bylaws stipulates the assessment year. This new section uses the same wording.

**Section 7 — Other Income** — Section 2, Article XI, page 11 of the current Constitution provides for other means of raising money. This new section uses the same wording.

## CHAPTER IV
## FUNDS

Sections 1, 2, 3, and 4, Article XI, pages 10-11 of the current Constitution cover assessments, income, expenses, and special funds. This new chapter refers strictly to funds.

**Section 1 — Special Funds** — Section 4, Article XI, page 11 of the current Constitution is transferred in full to this new section.

**Section 2 — Deposit of Monies and Special Funds** — The Executive Vice President shall deposit all monies of the Society received by him in such bank accounts as the Treasurer shall direct in accordance with the duties of that office.

Monies constituting the Medical Benevolence Fund shall be in a separate account and may be invested by the Treasurer under the direction of the Board of Trustees.

**Section 2 — Deposits of Monies and Special Funds** — Section 3, Chapter IX, pages 22-23 of the current Bylaws is transferred in full to this new section. The reference to Section 6, Chapter VI, page 20 in the current Bylaws is deleted since it is redundant.

**Section 3 — Medical Benevolence Fund** — Each year the Board of Trustees may appropriate a sum, not to exceed 15 percent of the annual assessment for all active members, to be set aside by the Treasurer as the Medical Benevolence Fund.

The Medical Benevolence Fund shall be used only for the relief of pecuniary distress of (a) sick or aged active and associate members or the parents, widows, widowers, or children of deceased active or associate members, and (b) active and associate members, resulting from catastrophic natural emergencies.

The Medical Benevolence Fund shall be under the absolute and confidential control of the Committee on Medical Benevolence.

Any money paid from the Fund shall not exceed any limitations imposed by the Board of Trustees. Money paid from the Fund requires approval by a majority of the Committee on Medical Benevolence by general or special resolution. The Medical Benevolence Fund shall be administered by the Secretary of this Society, who shall certify to the Treasurer all amounts paid from the Fund.

Every effort shall be made to keep the identity of Fund recipients confidential within the Committee on Medical Benevolence, necessary Society staff members, and the Board of Trustees.

**Section 3 — Medical Benevolence Fund** — Section 6, Chapter IX, page 23 of the current Bylaws is transferred in full to this new section slightly reworded as a result of editing.

**Section 4 — Educational Fund** — Each year the Board of Trustees, with the approval of the House of Delegates, may appropriate a sum not to exceed 15 percent of the annual assessment for all active members to be allocated to the Educational and Scientific Trust of the Pennsylvania Medical Society. The trustees of the said Trust shall set the sum aside in a special fund to be known as the Educational Fund.

The Educational Fund shall be used only to assist, by grants or loans, with or without interest, in paying the education expenses of children of living or deceased Society members. Such children must be (a) in high school, college, or graduate school, and in financial need; (b) in medical school, in financial need, and not qualified under clause (a) of this section, but who are residents of Pennsylvania and have been certified by the component society of the county in which they reside as needing financial aid to complete their medical education; or (c) in medical school and residents of Pennsylvania, who, by their superior scholastic achievements, have shown unusual promise. The trustees of the Educational and Scientific Trust, upon the recommendation of the Society's Committee on Aid to Education, shall select the recipients of loans or grants on the basis of character, scholastic ability, and, under clauses (a) and (b) above, financial need. No such loans or grants may be made without the approval by resolution of a majority of the

**Section 4 — Educational Funds** — The same wording of Section 7, Chapter IX, page 24 of the current Bylaws is transferred in full to this new section.

Committee on Aid to Education.

The Board of Trustees may establish further terms and conditions of the Educational Fund, within the general terms and for the purposes herein established, as it shall deem necessary and desirable.

Monies and special funds shall be disbursed by the Treasurer in accordance with specific or general resolutions of the Board of Trustees, or as provided in the bylaws.

## CHAPTER V
## LEGAL COUNSEL

**Section 1 — Appointment** — The Board of Trustees shall select a member of the Bar of Pennsylvania or a law firm practicing in Pennsylvania to act as legal counsel of this Society and shall determine the appropriate compensation.

**Section 2 — Duties** — Legal counsel of this Society shall advise the House of Delegates, the Board of Trustees, the Judicial Council, the committees, administrative councils, and commissions, and the staff on legal matters. All referrals of matters to legal counsel by committees, administrative councils, commissions, and staff shall first have the approval of the Executive Vice President in accordance with such discretionary authority as may be granted from time to time by the Board of Trustees.

## CHAPTER VI
## SEPARATION OF POWERS

**Section 1 — Legislative** — The House of Delegates shall be the legislative and policymaking body of this Society.

**Section 2 — Administrative** — The administrative body shall be the Board of Trustees, whose general and specific duties shall be prescribed in these bylaws.

**Section 3 — Judicial** — The judicial power of this Society shall be vested in the Judicial Council.

**Section 4 — Maintaining Separation of Powers** — To maintain the separation of powers of the three divisions the following restrictions shall prevail:

a. A member of this Society, if a voting member of the House of Delegates, may not at the same time serve on the Judicial Council, as a Trustee of the Board of Trustees, or as President, Immediate Past President, President Elect, Vice President, Treasurer, Secretary, or Speaker or Vice Speaker of the House of Delegates.

b. A member of this Society may not concurrently hold more than one office of this Society.

c. A member of the Judicial Council may not at the same time serve as a voting member of the House of Delegates, or

## CHAPTER V
## LEGAL COUNSEL

**Section 1 — Appointment** — Section 1, Chapter VIII, page 22 of the current Bylaws stipulates the appointment of legal counsel. This new section still provides for the Board to appoint legal counsel but adds that the Board determine the appropriate compensation.

**Section 2 — Duties** — Section 2, Chapter VIII, page 22 of the current Bylaws details the duties of legal counsel. This new section repeats the wording in full.

## CHAPTER VI
## SEPARATION OF POWERS

**Section 1 — Legislative** — Section 1, Article VI, page 4 of the current Constitution stipulates the House of Delegates as the legislative and policymaking body of this Society. This new section repeats the provision. (The Board of Trustees may establish policies in between meetings of the House of Delegates. This duty is detailed in Chapter XV of the revision.)

**Section 2 — Administrative** — Section 1, Article VIII, page 6 of the current Constitution charges the Board of Trustees with the property and financial affairs of this Society. Section 1, Chapter V, page 18 of the current Bylaws charges the Board with general supervision over all Society activity. The intent of both sections is embodied in this new section.

**Section 3 — Judicial** — Section 1, Article IX, page 7 of the current Constitution puts the judicial power of this Society in the Judicial Council. This new section repeats the provision.

**Section 4 — Maintaining Separation of Powers** — Article V, paragraphs a, b, and c, page 3 of the current Constitution delineates the restrictions which maintain the separation of powers of the three divisions of this Society. This new section fulfills the intent by outlining the capacities in which members may or may not serve.

as President, Immediate Past President, President Elect, Vice President, Treasurer, or Secretary of this Society, or as Speaker or Vice Speaker of the House of Delegates, or as a District Censor, or as a member of any council, commission, or administrative committee. A member of the Judicial Council, however, may be elected or appointed to a council, or committee which nominates persons to hold office or receive awards, or which is purely advisory in nature.

## CHAPTER VII
## ANNUAL MEETING OF THE HOUSE OF DELEGATES

**Section 1 — Designation** — There shall be an annual meeting of the House of Delegates which shall convene at a place previously determined by the House of Delegates and at such time as determined by the Board of Trustees. The Board of Trustees may cancel or change the date or place of the meeting in case of strikes, government regulations, catastrophes, or other reasons beyond the control of this Society.

**Section 2 — Business to be Conducted** — Business to be conducted shall include that which is required by and in accordance with these Bylaws, including consideration of annual and official reports, and resolutions and reports appropriately received. Such business also may include installation of the incoming President and other officers, and other matters related to this Society, including scientific business, business which may require action by the voting members of this Society as prescribed by the laws of the Commonwealth of Pennsylvania, and matters requiring the advice of the House of Delegates to any body of this Society.

**Section 3 — The Official Call** — The Society Secretary shall issue an Official Call to the Annual Meeting of the House of Delegates to the members of this Society at least 60 days prior to the annual meeting. This Official Call may be by mail or by publication in the journal of this Society. The Official Call shall include, but not be limited to: (a) the time and place of the meeting; (b) the nominees for delegates and alternates to the House of Delegates of the American Medical Association submitted by the Committee to Nominate Delegates to the American Medical Association; and (c) such other information deemed appropriate by the Secretary.

If it becomes necessary to change the time or place of the Annual Meeting of the House of Delegates after the Official Call has been issued, an additional call shall be issued by the Secretary by mail or by publication in the journal not later than 15 days prior to the convening of the meeting.

## CHAPTER VIII
## SPECIAL MEETING OF THE HOUSE OF DELEGATES

**Section 1 — Designation** — There may be special meetings of the House of Delegates. A special meeting may be requested at any time by (a) 9 members of the Board of

## CHAPTER VII
## ANNUAL MEETING OF THE HOUSE OF DELEGATES

**Section 1 — Designation** — Section 1, Article VII, page 5 of the current Constitution provides for an annual "session" of the House of Delegates. According to *Sturgis Standard Code of Parliamentary Procedure,* the term, session, should not apply to an annual meeting but rather to portions of the annual meeting. This new section stipulates that the House of Delegates meet annually at a place previously determined by the House. Hereafter, the term, session, applies only to the days of the annual meeting.

**Section 2 — Business to be Conducted** — Section 3, Article VII, page 6 of the current Constitution describes the business for both annual and special meetings. This new section describes the business which may be conducted at annual meetings and includes the same general guidelines in simpler language. However, the specific reference to reports and resolutions is added since these are the official "vehicles" for presentation of business to the House. Business for a special meeting is discussed in Chapter VIII of the proposed revision.

**Section 3 — The Official Call** — Section 1, Article VII, page 5 of the current Constitution describes the method, content, and timetable necessary for issuing the Official Call. This section repeats the same criteria in simpler language.

## CHAPTER VIII
## SPECIAL MEETING OF THE HOUSE OF DELEGATES

**Section 1 — Designation** — Section 2, Article VII, pages 5 and 6 of the current Constitution designates the manner in which the House may convene a special meeting. The current section also states that the business to be conducted must be expressly stated in the call to the meeting

Trustees; or (b) 40 voting members of the House of Delegates; or (c) 200 active, or associate members of this Society, provided such special meeting has the approval of a component society or societies having an aggregate membership of at least 200 physicians.

Any such request must be in writing and delivered to the Secretary of this Society, who shall affix the time and place for the special meeting.

**Section 2 — Business to be Conducted** — The business to be conducted must be within the jurisdiction of the House of Delegates and in accordance with these Bylaws, and may include other matters related to this Society, including scientific business, business which may require action by the voting members of this Society if so prescribed by the laws of the Commonwealth of Pennsylvania, and matters requiring the advice of the House of Delegates to any body of this Society.

Only that business expressly stated in the Official Call to the Special Meeting may be conducted at that meeting of the House of Delegates.

**Section 3 — The Official Call to a Special Meeting of the House of Delegates** — The Society Secretary shall issue an Official Call to the special meeting stating the place and time for this meeting, which shall be not less than 14 nor more than 90 days after receipt of the request. The Official Call to the meeting shall be by mail or by publication in the journal of this Society, and shall expressly state the business to be conducted at the special meeting.

and describes the method, content, and timetable for the call.

This new section has the same criteria to call a special meeting of the House of Delegates. For clarity, however, a new Section 2 describes the business to be conducted at a special meeting. The specifics for the call to the special meeting are described in a new Section 3 of the proposed revision.

**Section 2 — Business to be Conducted** — Please see note for Section1, above. This new section repeats the criteria for business which may be conducted in simpler language than that in Section 2, Article VII, pages 5 and 6 of the current Constitution.

**Section 3 — The Official Call to a Special Meeting of the House of Delegates** — Please see note for Section 1, above. This new section repeats the criteria for the call in simpler language.

**SPECIAL NOTE: The reference to scientific assemblies has been omitted in the revision since scientific assemblies as such were discontinued several years ago. However, Section 2, Chapter VIII in this revision includes conducting scientific business at an annual meeting. Sections 1, 2, and 3, Chapter II of the current Bylaws, are eliminated.**

**Section 1 — General Meetings** — This refers to a meeting of the membership-at-large and not a meeting of the House of Delegates. The installation of the incoming President and other officers has occurred at the State Dinner which has been considered a general meeting of this Society at which the President presides.

The proposed revision eliminates Section 1, Chapter II, page 15, of the current Bylaws. Under this proposed change, the State Dinner becomes purely a social function not to be confused with the annual meeting of the House of Delegates. Chapter VII, Section 2 of the proposed revision provides for this function, whether in the House or at a state dinner.

The introduction of guests and officers, the necrology report, and business for the membership are all included in the Order of Business for an annual meeting.

**Section 2 — Scientific Assemblies** (page 15) — Such assemblies have been eliminated by prior decision of the House of Delegates.

**Section 3 — Registration** — Section 3, Chapter II, page 15 of the current Bylaws is unnecessary due to the preceding deletions. However, a requirement for general registration may be found in a later chapter of this proposed revision.

# classifieds

## PHYSICIANS WANTED

**House physicians** — Modern hospital has openings for licensed MDs to provide inpatient coverage days, evenings, nights, and/or weekends. Attractive annual salary plus fringe benefits. Interested candidates send resume to: B-33, P.O. Box 2069, Philadelphia, PA 19103. Equal Opportunity Employer.

**Primary care** — internal medicine. Position available in private practice. Main Line area of Philadelphia. Excellent opportunity with two older primary care physicians in internal medicine. Base salary $30,000 plus incentive bonus. If interested, write Department 841, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043 for appointment and interview.

**Emergency physicians** — join fee for service group in central Pennsylvania. Excellent salary and fringe benefits. Send CV including your telephone number to: Community Physicians Inc., P.O. Box 411, Camp Hill, PA 17011; (717) 737-9430.

**Medical director/Clinical director/Staff physician** — state geriatric center, South Central Pennsylvania. Easily accessible to Washington, D.C., Baltimore, Philadelphia, Harrisburg. Good salary with exceptional benefits, retirement plan, and professional liability. 37.5 hour work week. Pennsylvania license required. Contact Robert T. Gray, MD, South Mountain Restoration Center, South Mountain, PA 17261; (717) 749-3121.

**Surgical technologist** — or surgical assistant (P.A.). 381 bed community hospital, N.E. section of Philadelphia, Pennsylvania. Full time; salary competitive. Contact Nazareth Hospital (215) 331-8000 ext. 395.

**Orthopedic surgeon wanted** — associate for well established orthopedic clinic in eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Physicians** — for clients in Pennsylvania and Massachusetts. Specialists in FP, PD, ENT, psychiatry, physical medicine, and a director Ob-Gyn. Please call E.J. Mowry, (215) 348-8700.

**Resident physicians** — wanted for well-established children's sleepaway camp, Wayne County, Pennsylvania. Two and four weeks available in July. 2 RNs on duty. Families accommodated and are welcome to participate in all activities. Call (516) 466-8698 collect evenings.

**Obstetrician/Gynecologist needed** — Board eligible or certified, full-time position for a multispecialty primary care center. Located in Northeastern Pennsylvania, 20 minutes from Pocono Mountain resorts and within two hours of New York City and Philadelphia. Position available on or before July 1. Competitive salary and fringe benefits. Contact Alfonso Gomar, MD, Medical Director, 959 Wyoming Avenue, Scranton, PA 18509, (717) 344-9684. Scranton Primary Health Care Center is an Affirmative Action, Equal Opportunity Employer.

**Pediatrician wanted** — to join two pediatricians for existing vacancy in three man department. This is part of a multi-specialty group of primary care physicians located in Northwest Pennsylvania. This group has been established for 33 years and serves a patient population area of 75,000. There are new office facilities fully equipped and ready for occupancy. Full membership in the corporation will be offered after one year. A very moderate investment is required. We offer an excellent starting salary and a full range of fringe benefits. Contact Robert W. Monroe, MD, Greenville Medical Center, 90 Shenango Street, Greenville, PA 16125, telephone (412) 588-4240.

**Good opportunity G.P./F.P.** — for growing area near university, tremendous potential and urgent need. Private practice in central western Pennsylvania. Will sponsor and guarantee. Dr. S.W. Greenwald, 290 Grant St., Indiana, PA 15701, phone (412) 463-0508 or 479-2800.

**Obstetrician-Gynecologist** — Indiana, Pennsylvania — A beautiful university community located 60 miles north and east of Pittsburgh, PA. Indiana Hospital is a 200-bed general hospital, completing a $22 million building and renovation program, which will provide the finest in medical facilities and equipment. It is the only general hospital in Indiana County, serving a population of over 80,000. The potential for a medical practice in obstetrics and gynecology is excellent due to a strong expanding economy and a young family growth in this area which has generated the need for additional physicians in this specialty. The area has an excellent school system, fine recreational facilities with lakes, streams, and mountain terrain for the various sports. The practice opportunity is open either for a private practice or in a partnership. Inquiries should be directed to either Richard N. Freda, MD, The Ben Franklin Medical Center, Shelley Dr., Indiana, PA 15701 (412) 463-0225 or Donald F. Smith, President, Indiana Hospital, Indiana, PA 15701 (412) 357-7120.

**Emergency physician** — to join congenial six man group. Northwestern Pennsylvania 600 bed general hospital; 50,000 annual ED visits. Training in either Emergency Medicine or Surgery. Leadership or administrative experience desirable. Clean metropolitan community of 265,000; five area colleges; many cultural and recreational opportunities; year round outdoor activities. Join professional corporation after one year; 80K; fringes. Send C.V. to Department 840, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Pennsylvania** — Emergency physician system. Needs several fulltime emergency physicians for Western Pennsylvania area emergency departments. Independent contractor arrangements. Eligible for corporate membership within two years. The system is on a "fee-for-service" basis. Contact: (412) 228-3400 for interview appointment.

**Camp physicians needed** — Camp Chen-A-Wanda, fine Pennsylvania Co-ed camp, season begins June 28, ends August 23. Physicians accepted for two weeks to four weeks. Excellent living accommodations for physician and family. Write: Mr. and Mrs. Morey Baldwin, 8 Claverton Court, Dix Hills, NY 11747. Call collect (516) 643-5878 (evenings).

**Career opportunities** — Throughout Pennsylvania and from coast-to-coast for physicians in all specialties. All Fees assumed by employers. Send CV with objectives to Medical Recruitment Division, Dr. Personnel of Pittsburgh, Inc., (31 offices nationwide), 121 University Place, Pittsburgh, PA 15213, (412) 621-9975.

**Pediatrician and other physicians wanted** — for Bethel Park, Pennsylvania, suburb of Pittsburgh, 35,000 people. New professional building. Call (412) 833-6188.

**Unique opportunity** — for practice of family medicine, pediatrics, or internal medicine in Southeastern Pennsylvania. Attractive new office space. Write Department 837, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Physician placement by physicians** — unique hospital, group, and solo opportunities available in **all** specialties throughout Pennsylvania and coast-to-coast. Urban, suburban, and rural openings. Forward C.V. with your objectives in confidence to M.C. Staschak, MD, & Associates, 5th Floor - M, Manor Building, Pittsburgh, PA 15219, (412) 765-3555 (answers 24 hours).

**General surgeon** — North Carolina. Needed for University owned hospital in small coastal town. This private practice opportunity is ideal for an experienced general surgeon who would enjoy a relaxed, productive life style in a desirable climate on the coast. Send CV to Department 839, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Ophthalmologist** — Retinal specialist to associate with busy general ophthalmologist in Philadelphia. This might be a part-time association. Please send curriculum vitae in reply to Department 838, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Emergency room physician** — Immediate opening for full time emergency room physician. Salary and fringe benefits are competitive. Send resume to Mr. Richard A. Anderson, Administrator, Canonsburg General Hospital, Barr Street, Canonsburg, PA 15317.

**Psychiatrists and physicians** — Board certified or Board eligible Pennsylvania Licensure required. Immediate openings. Excellent opportunity to work in developing new programs in a state hospital. Salary competitive. Limited housing available. Excellent fringe benefits. 40 miles east of Pittsburgh. Call (412) 459-8000 or write to Ray Bullard, MD, Superintendent, Torrance State Hospital, Torrance, PA 15779. An Equal Opportunity Employer.

**Emergency medicine opportunities available** — Opportunities available to assume clinical and directorship responsibilities in several emergency departments located in western Pennsylvania. Excellent income, flexible scheduling, and paid professional liability insurance. Part-time opportunities also available. For details, send credentials in confidence to Mr. James Thomas, 230 Park Avenue, Suite 303, New York, New York 10169, or call collect (212) 599-0060.

**Family practitioner** — Tampa Bay Area, Florida. Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., Attn: Jerry Williamson, MD, 1417 South Belcher Road, Clearwater, Florida 33516; (813) 535-3474.

**Internist** — Tampa Bay Area, Florida. Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, MD, Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516; (813) 535-3474.

**Pennsylvania Emergency Physician** — 200-bed general hospital located in western Pennsylvania university community. New modern Emergency Department. Salary highly competitive. PA license required. Contact: William B. Yeagley, MD, Director of Department of Emergency Services, Indiana Hospital, Indiana, PA 15701.

**NEEMA Emergency Medical** — a professional association — Emergency medicine positions available with emergency physician groups throughout Pennsylvania, New York, New Jersey, Michigan, and Southeastern U.S., including all suburban, rural, and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to NEEMA Emergency Medical, Suite 400, 399 Market St., Philadelphia, PA 19106. In PA call (215) 925-3511, those outside of PA call 1-800-523-0776.

**House Staff Physician** — Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $40,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Executive Director, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

**Psychiatrist** — board-certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact George E. Gittens, MD, Acting Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411, (717) 586-2011.

**Medical director** — Allied Services, located at the foothills of the scenic Pocono Mountains, is the largest comprehensive-care rehabilitation facility in the eastern United States. Allied is currently seeking a board certified physiatrist for the position of medical director, who will be responsible for the overall medical services of the accredited 90-bed Institute of Rehabilitation Medicine, and supervise a full-time physiatry staff. The position offers tremendous opportunity, salary, and fringe benefits. For more information, call collect (717) 348-1343, Michael J. Aronica, MD, Allied Services, 475 Morgan Highway, Scranton, PA 18508.

**Emergency physicians** — Philadelphia and suburban Philadelphia hospitals. Fee for service with minimum guarantee, 42 hr. per week avg. Experience preferred but will consider all applicants. Contact Teddy Trout (215) 438-0390 for further details or send CV to EMSS, 5555 Wissahickon Ave., Suite L6, Philadelphia, PA 19144.

## FOR SALE

**Ten room house** — and seven room adjoining office in community ten miles east of Hershey. Practice for price of home. Ideal for dermatologist, allergist, or general practitioner. Contact Nelson S. Scharadin, MD, 102 East Penn Avenue, Cleona, PA 17042; (717) 272-0302.

**Allentown, Pa., suburb** — unique circular contemporary overlooking the Lehigh Valley. Computerized kitchen with 64 ft. of cabinets, 2 round fireplaces, 6 bedrooms, 3 baths. Offered at $134,000. Craig Scharadin Real Estate, 2640 Walbert Avenue, Allentown, PA 18104; (215) 435-5104.

## MISCELLANEOUS

**Financial Planning-Tax Havens** — Reduce personal tax liability. Increase net worth. Improve profitability of your private, group, or corporate practice. Reduce, defer, or eliminate Federal/State taxes—legally. U.S. Tax Planning Corporation conducts seminars for doctors nationally (see advertisement this issue). For information, call toll-free 1-800-543-3000-operator, 220 anytime.

**Physician's assistants** — Become a warrant officer in the Pennsylvania Army National Guard in a unit near your home. Serve one weekend a month and a fifteen (15) day annual training period each year. You will be eligible for continuing professional education, monthly pay, and a substantial non-contributory retirement plan. Enjoy the personal satisfaction of doing an important job for your state and nation. For further information contact Major Eugene P. Klynoot, Department of Military Affairs, Pennsylvania Army National Guard, Annville, PA 17003. Telephone (717) 783-3430.

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# BACTRIM™ ROCHE
(trimethoprim and sulfamethoxazole)

## *A MAJOR ANTIMICROBIAL WITH MULTISYSTEM USEFULNESS*

The clinical usefulness of Bactrim continues to grow. Now Bactrim is useful for all of the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

***UPPER RESPIRATORY***

acute otitis media in children

***LOWER RESPIRATORY***

acute exacerbations of chronic bronchitis in adults —documented *Pneumocystis carinii* pneumonitis

***GENITO-URINARY***

recurrent urinary tract infections

***GASTRO-INTESTINAL***

shigellosis

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

**For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.**

**For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.**

**For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.**

**Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.**

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage: Not recommended for infants less than two months of age.**

*URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:*

*Adults:* Usual adult dosage for urinary tract infections — 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

*Children:* Recommended dosage for children with urinary tract infections or acute otitis media — 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

*For patients with renal impairment:* Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

*ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:*

*Usual adult dosage:* 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

*PNEUMOCYSTIS CARINII PNEUMONITIS:*

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediotric Suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; cherry flavored—bottles of 16 oz (1 pint). *Suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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# BACTRIM™

(trimethoprim and sulfamethoxazole)

## A major antimicrobial with multisystem usefulness

Clinical applications for Bactrim continue to grow. Now Bactrim is useful for all of the following infections when due to susceptible strains of indicated organisms (for specific organisms, see indications section in product information on other side):

1. *UPPER RESPIRATORY* —acute otitis media in children
2. *LOWER RESPIRATORY* —acute exacerbations of chronic bronchitis in adults; documented *Pneumocystis carinii* pneumonitis
3. *GENITOURINARY* —recurrent urinary tract infections
4. *GASTROINTESTINAL* —shigellosis

☐ Dual action minimizes development of resistance
☐ *In vitro* spectrum includes ampicillin-resistant *H. influenzae*
☐ May be used in patients allergic to penicillins and cephalosporins
☐ B.I.D. dosage (except for *Pneumocystis carinii* pneumonitis) encourages compliance
☐ Contraindicated during pregnancy and lactation and in infants less than 2 months of age

*BACTRIM — EFFECTIVE, ECONOMICAL AND CONVENIENT B.I.D. DOSAGE*

Please see preceding page for summary of product information.

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# Pennsylvania Medicine

Vol. 83, No. 7 JULY 1980

## Children Bearing Children

2443
NLM IND MED TITLES
P O BOX 517
BERWYN PA 19312

# The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

## The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

## Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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**Contraindications:** Hypersensitivity to the drug.
**Precautions:** *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
**Adverse Reactions:** Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
**Dosage and Administration:** 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
**How Supplied: Hydergine tablets (for oral use) 1 mg,** packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
*Before prescribing, see package insert for full product information.*

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# medigram

BOARD OF TRUSTEES STUDIES PROPOSED CAT FUND CHANGES

Pennsylvania's $1 million excess coverage for medical malpractice, established by Act 111 of 1975, is in trouble. The PMS Board of Trustees on June 18 heard a full report on the status of the Catastrophe Loss (CAT) Fund, and will assess possible solutions in the period before its August 20 meeting. Henry H. Fetterman, MD, chairman of the Board's ad hoc committee on Act 111, presented the committee's report, with the following amendments to Act 111 to assure survival of the Fund:

1. Require the Joint Underwriting Association to reimburse the Fund for any payouts made for the JUA.
2. Permit primary insurers to agree to a settlement before the CAT Fund settles a claim.
3. Remove the 10 percent cap on the premium surcharge which supports the Fund, permit an additional emergency surcharge if necessary, and establish a schedule for orderly operation of the Fund.
4. Eliminate the $7.5 million floor (if the Fund drops to that level, its sunset provisions are activated) and substitute a $15 million floating cushion.
5. Increase the basic limits of physicians' insurance, now $100,000/$300,000, only if the Fund pays out more than $20 million in 1981 or beyond, to $150,000/$450,000. Basic limits coverage would increase to $200,000/$600,000 if the Fund pays more than $30 million in 1983 or beyond. The committee agreed to the increasing of basic limits after winning its argument that increased limits be imposed only after increased payouts were a reality. A study of the cost of $1 million coverage in other states shows that Pennsylvania physicians still have a bargain in the CAT Fund.

PMS WINS LINE IN BUDGET, $2 INCREASE IN FEES

Governor Dick Thornburgh signed the Commonwealth's 1980-81 budget June 18. For the first time the budget has two lines for the medicaid appropriation, one marked institutional, the other noninstitutional. The budget also provides for a $2.00 increase in the fee for a visit by a medicaid patient to a physician's office. The fee increase from $6.00 to $8.00 becomes effective July 1, 1980, according to MA Memorandum No. 187. Because of the second line, funds may exist to provide an additional fee increase later in the fiscal year. Physicians and medical assistance patients bombarded the Legislature with demands for improving the medical assistance program, and can be credited with the "first step" victory.

SOCIETY REPRESENTATIVES SEE GOVERNOR THORNBURGH

Three Society representatives met June 10 with Governor Dick Thornburgh to discuss several issues. Matthew Marshall, Jr., MD, president; John F. Rineman, executive vice president; and Robert H. Craig, director of legislation, pressed PMS positions at the session. Governor Thornburgh pledged an effort to settle the Society's suit to force the Commonwealth to put physicians' registration fees at

the disposal of the State Board of Medical Education and Licensure, as required by law. On medicaid patients' office visits, the governor reiterated his position that the new $8.00 is insufficient, but said he hopes that physicians will view this initial increase as a signal that the administration will seek further increases. Dr. Marshall also explained physicians' objections to the cumbersome "provider agreement" of the Department of Public Welfare. The governor promised to investigate the agreement, which the Society opposes.

SURVEY OF SOCIETY MEMBERS BRINGS 5,000+ RESPONSES

A nearly 40 percent response to Hay Associates survey of PMS members surprised the professional opinion seekers, who expected only a 20-24 percent reply. The survey results will be available when the Board of Trustees meets in a special planning session September 13-14 at Society headquarters.

PMS DELEGATION PREPARES FOR AMA HOUSE MEETING

The PMS Delegation's headquarters will be busy at the AMA House of Delegates annual meeting in Chicago July 20-23. Pennsylvanians seeking re-election are: William Y. Rial, MD, speaker of the AMA House; George A. Rowland, MD, AMA Board of Trustees; Betty L. Cottle, MD, Council on Constitution and Bylaws; and James B. Snow, Jr., MD, Council on Scientific Affairs. William J. Kelly, MD, will serve as a reference committee member. John F. Rineman, executive vice president, will be installed as president of the American Association of Medical Society Executives at a ceremony on July 19. John B. Lovette, MD, is chairman of the Pennsylvania Delegation.

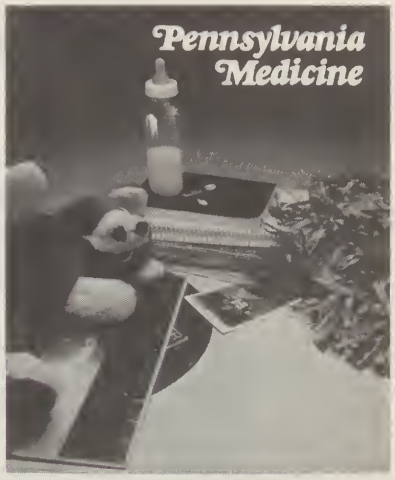
PMS PRESIDENT MARSHALL ASKS MEETING WITH HHS OFFICIALS

Matthew Marshall, Jr., MD, PMS president, has written to Nathan J. Stark, undersecretary of the Department of Health and Human Services, seeking a meeting on the "deepening crisis facing the medicaid program across the country, nowhere more critical than in Pennsylvania." Dr. Marshall expressed PMS concern about low physician reimbursement and the welfare department's insistence that physicians sign the proposed six-page provider agreement. Stark is on leave of absence from his position as senior vice chancellor for health sciences at the University of Pittsburgh. At Pitt from 1974 until his leave began last fall, he oversaw the operations of six schools and served as president of the University Health Center of Pittsburgh.

PMS SUPPORTS REDUCTION OF UNNECESSARY TESTING

The Board of Trustees on June 18 approved a recommendation to support Blue Cross of Western Pennsylvania in its efforts to reduce the number of unnecessary and routine tests performed in hospitals in its service area. Included are certain pre-admission tests except when ordered by the physician. The plan also seeks to eliminate the performance of 86 procedures identified as obsolete by the American College of Physicians, American College of Radiology, American College of Surgeons, and the American Hospital Association. The PMS Board urged Blue Cross of Western Pennsylvania to monitor the cost effectiveness of its effort.

Pennsylvania Medicine

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*Cover photograph by Doug and Cindi Nicotera*

**PENNSYLVANIA MEDICINE**
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

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offers

# CONSULTATIONS IN INTERNAL MEDICINE

Wednesdays, 4 to 7 P.M. October 10 to December 17, 1980

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## COURSE DESCRIPTION

**317.** This highly successful clinical problem-solving course is for experienced physicians practicing general internal medicine. The objective is to analyze, systematically, a series of difficult patient management problems commonly encountered in office and hospital practice. Special attention is given to diagnostic and therapeutic dilemmas presenting in the ambulatory setting.

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*30 Category I credit hours; 30 AAFP prescribed credit hours (pending)*

**Also . . .**

### CLINICAL TUTORIAL — 152. Dermatology For The Practicing Physician

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Specifically designed for non-dermatologist physicians, especially those involved in primary care practice. Major emphasis is on unraveling diagnostic possibilities in a presenting dermatological complaint and providing practical guidelines for relieving the patient's symptoms and promoting resolution while the evaluation is proceeding. Special attention is given to the most commonly encountered dermatological problems in general office practice. Teaching includes lectures, case presentations, group discussion and a forum for presenting specific diagnostic and management problems from the registrant's practice.

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Wednesdays, 1:30 to 3:30 P.M. October 29 to December 3, 1980
(No session November 26)

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This course is for the non-cardiologist physician. It provides clear and specific guidelines for the application of non-invasive diagnostic procedures in ambulatory and hospital practice to assist the physician in properly ordering and sequencing these examinations, in interpreting reports from consultants and in better understanding the clinical literature. Each presentation begins with a clear description of the physical principles underlying the procedure. This is followed by a review of indications, contraindications and test limitations. There is a comparison of information from non-invasive with invasive (catheterization) procedures with special reference to the value of the information in patient management as well as risks, costs and patient suffering. Case studies illustrate how non-invasive procedures are applied, their proper sequence in the diagnostic work-up and in their interpretation. The instrumentation for each procedure is described and demonstrated and there are review practice sessions for interpreting diagnostic data. Topics include: Basic Concepts of M-Mode Echocardiography including Recognition of Valvular, Congenital and Pericardial Disease and Cardiomyophathies; Radionuclides including the Evaluation of Cardiac Performance and the Recognition of Ischemic Disorders; Holter Monitoring; Systolic Time Intervals; Phonocardiography, Apexcardiography and Arterial and Venous Tracings; When to invade: The Limitations of Non-Invasive Cardiology; Stress Testing; Dynamic Imaging. This course does not require any previous familiarity with non-invasive cardiology.

*10 Category 1 credit hours; 10 AAFP prescribed credit hours (pending)*

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# editorial

## Returning to competitive market in health care

> 'If a nation values anything more than freedom, it will lose its freedom; and the irony of it is that if it is comfort or money that it values more, it will lose that too. Regulations sacrifice a measure of individual freedom for the comfort and welfare of the many as perceived by the few. We are approaching the illogical extreme where government controls all.'

Deregulation in health care? A forlorn hope, you say. Each day some new form needs a signature or some new rule change is implemented. It appears to the cynic that no end is in sight. An economy that began as *laissez faire,* no-holds barred competition is scarcely recognizable today.

Rising costs in health care have not been eased by liberal applications of regulations. Yet there are those who continue to follow this bureaucratic offering. On the other hand, there are some advocates of a return to a competitive market partly through the development of HMOs. Economic competition in health care, if it can be achieved, is much preferable to the myriads of counterproductive government regulations that have evolved.

In the era before regulatory statutes, the economy was influenced by Jeffersonian ideals which frowned upon government interference with business. The post-Civil War period brought the age of the Robber Barons who practiced a kind of socio-economic Darwinism, *i.e.* only the fittest survived the brutal competition. Working conditions were grim. Monopolies fixed prices in one of many attempts to gouge other businesses and consumers as well.

In 1887, the Interstate Commerce Act was passed and three years later, in 1890, the Sherman Anti-Trust Law was enacted. These two laws established an unheard of precedent in providing for the public welfare over that of monopolies. When the Interstate Commerce Commission expanded, it was able to establish maximum rates.

Federal regulation grew in the years that followed. Laws curbed rebates. Laws provided for federal inspections. Laws governed adulteration and mislabeling of food and drugs. In general, laws curbed excesses of business.

These two acts, early attempts at regulatory reform by the government, resulted in the need to support the busi-Act (1915) and the Jones-White Act (1928). The La Follette Seamans Act, which required decent wages, treatment, and food, a much needed reform, made competition with low-paying foreign shipping difficult. The act thus hurt the American merchant marine. The Jones-White Act was a government attempt to encourage shipping through subsidies thinly disguised as mail contracts.

These two acts, early attempts at regulatory reform by the government, resulted in the need to support the business so regulated. This pattern has continued through the succeeding decades to the present. It has become the government's attitude that legislation must be enacted not only to prevent the excesses of business (kickbacks, false advertising, bribery) but also to protect business from competition. Big brother now allegedly provides for the general public welfare and sustains business through low-interest loans (Chrysler Corporation), protection from competition, and price supports, all of which are expensive.

Medicine, although not commonly thought of as a business in the true sense of the word, gradually has fallen under the government's regulatory policies. Deregulation and a return to a free economic competitive system in health probably will encounter strong opposition primarily from bureaucrats who will be threatened. But the time for a beginning is upon us. The time for a move toward a competitive market is now.

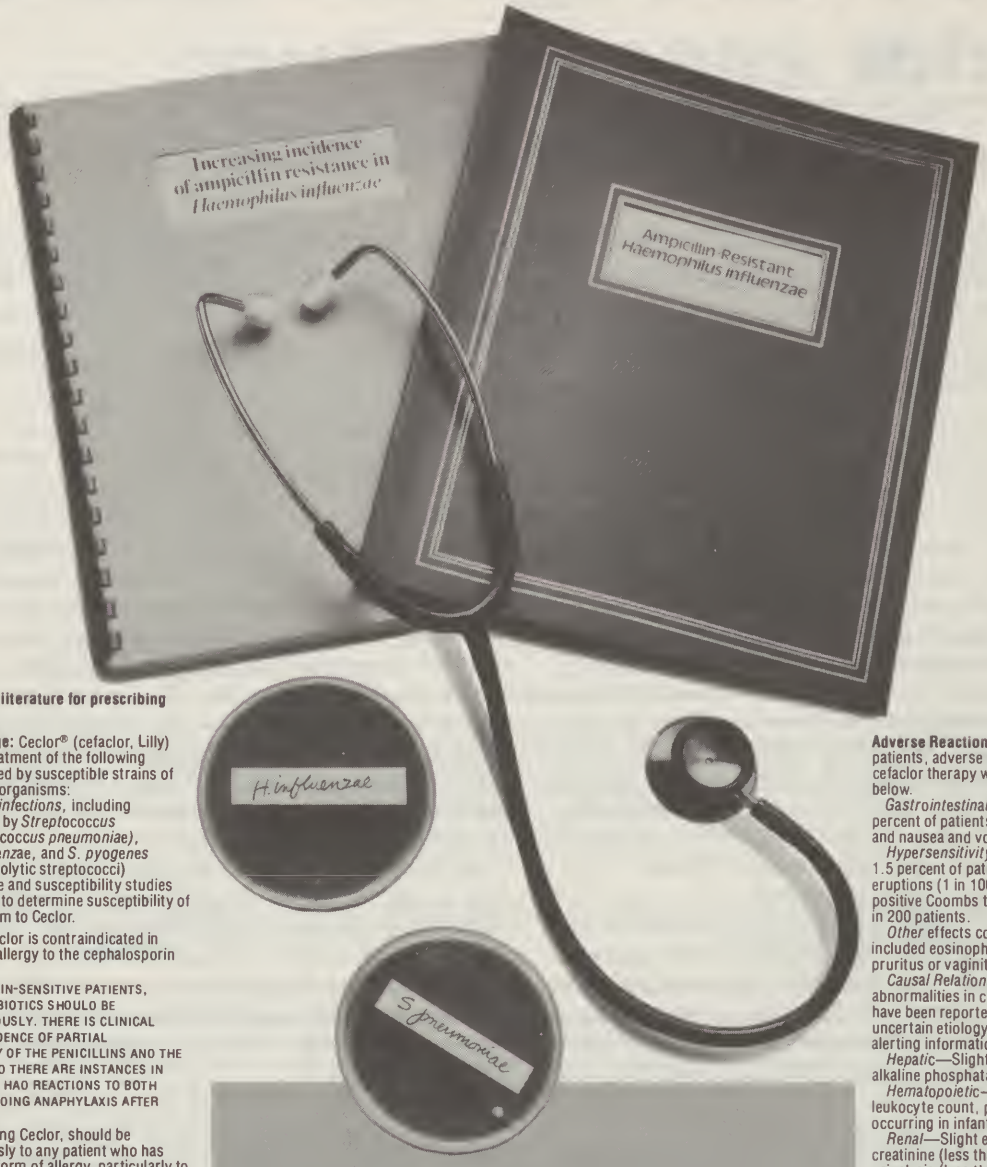
The public mood is one of distrust of political leadership and big government. Regulatory development required decades of careful fermentation so we must not expect to re-achieve economic competition over night.

Somerset Maugham wrote, "If a nation values anything more than freedom, it will lose its freedom; and the irony of it is that if it is comfort or money that it values more, it will lose that too." Regulations sacrifice a measure of individual freedom for the comfort and welfare of the many as perceived by the few. We are approaching the illogical extreme where government controls all.

This year we elect a president, many new chief executives in states, representatives, and senators. Doctors, both organized and individually, must support, bring pressure where necessary, and promote where possible all of the changes needed to prevent the excesses of the bureaucracy. Legislative revision of regulation must be brought to counteract the regulation introduced in the late 1800s and early 1900s.

David A. Smith, MD
Medical Editor

# An added complication... in the treatment of bacterial bronchitis*




**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

**Ceclor®**
**cefaclor**

Pulvules®, 250 and 500 mg

**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage:** Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note:* Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.*

Lilly

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# newsfronts

## Pennsylvania schools confer degrees on 1315 physicians

Kathy Lee Santangelo

The first new physicians of the decade received their medical doctor or doctor of osteopathy degrees in May and June, 1980. A total of 1315 men and women graduated as medical professionals from the state's seven medical schools and one osteopathic medical college. Less than 50 percent of the 997 male and 318 female graduates accepted residencies in Pennsylvania.

**Hahnemann**

Hahnemann Medical College conferred MD degrees on 188 men and women at its 133rd commencement, June 4, 1980. Of the new physicians, 154 are men and 34 are women. Ten of the graduates represented the first group of participants to complete the Lehigh-Hahnemann Medical Development/Pennsylvania Program. The Wilkes-Hahnemann MD/Pa Program graduated its third class with 23 students. These physicians accepted residencies in the primary care specialties of internal medicine, family practice, and pediatrics. Ninety-two members of the entire class accepted residencies in Pennsylvania.

**Jefferson**

Two hundred twenty-one men and women received MD degrees from Jefferson Medical College at its 156th commencement, June 6, 1980. The class was the largest group of 1980 medical graduates in the Commonwealth. Of the 178 men and 43 women, 117 accepted residencies in Pennsylvania. Internal medicine ranked first among the three major specialty preferences of the graduates. Surgery and family practice followed.

**MCP**

The Medical College of Pennsylvania conferred degrees at its 128th commencement, May 17, 1980. MCP graduated 64 women and 53 men. Forty-eight of the 117 new physicians accepted residencies in Pennsylvania.

**Hershey**

The state's newest medical school, Pennsylvania State University College of Medicine, graduated 96 men and women. Hershey's 10th commencement was held May 24, 1980. Seventy-four men and 22 women received MD degrees. More than 50 percent of the graduates accepted residencies in the primary care specialties of medicine, family medicine, internal medicine, and pediatrics.

**PCOM**

The degree of doctor of osteopathy was conferred on 202 graduates by the Philadelphia College of Osteopathic Medicine. At its 89th commencement, June 8, 1980, PCOM graduated 164 men and 38 women.

**Temple**

Temple University School of Medicine conferred medical doctor degrees on 187 men and women at its 94th commencement, May 29, 1980. Thirty-seven women and 150 men graduated. The class included 15 new physicians with previous master's degrees, and two with PhDs. Fourteen of the graduates were over 30 years old.

**Penn**

At University of Pennsylvania School of Medicine, 164 received MD degrees on May 19, 1980, including 117 men and 47 women. Sixty-eight of the graduates will remain in Pennsylvania during their residencies. Among their specialty preferences, internal medicine ranked first as 65 of the new physicians accepted residencies in medicine. Surgery ranked second, and pediatrics, family practice, and obstetrics/gynecology attracted the majority of the remaining graduates.

**Pitt**

Commencement at the University of Pittsburgh School of Medicine, May 27, 1980, featured 140 men and women who had earned medical doctor degrees. The class comprised 107 men and 33 women. Fifty-one of the graduates accepted residencies in medicine. Another 64 graduates accepted hospital appointments in surgery, pediatrics, family practice, and obstetrics/gynecology. Fifty percent of the graduates will receive residency training in Pennsylvania hospitals.

**Alice M. Swift, associate director for planning, evaluation, and legislation in the Division of Health Professions and Training Support of the U.S. Department of Health and Human Services, received recognition at the 7th Annual Financial Aid Officers' Workshop, May 22, 1980. The PMS Educational and Scientific Trust, sponsor of the workshops, and the eight participating financial aid officers of the state's medical schools awarded her a plaque for her seven years of participation and support in the annual workshops.**

# Court upholds revocation of MD's staff privileges

**Fred Speaker, Esq.**

Strict obedience to medical staff bylaw provisions, and to the traditional rules of evidence, is not essential according to the decision of the Pennsylvania Superior Court in *Miller v. Indiana Hospital.*[1]

In that case a patient who was under the care of Ralph Miller, MD died at the Indiana Hospital. The following day another physician sent a report to the medical staff and stated that the quality of care which had been rendered was below that which should have been accepted at any hospital.

Five days later the president sent Dr. Miller an invitation to attend the meeting of the executive committee concerning the charges which had been made against him. Two days later the complaining physician sent another letter to the executive committee formally requesting that action be taken to suspend Dr. Miller's staff privileges. Two days later the executive committee held an informal meeting which Dr. Miller attended but he refused to discuss the charges against him and left the meeting.

A month after the initial complaint the executive committee sent written notice of its determination to recommend revocation of Dr. Miller's staff privileges to the hospital directors. Dr. Miller demanded a hearing and the executive committee thereupon informed him of the hearing date and provided him with a list of charges and a list of proposed witnesses. The list of charges went beyond those included in the original complaint letter.

Dr. Miller requested an appointment of an impartial ad hoc committee to conduct the meeting and the executive committee denied the request and held a hearing for several days approximately four months after the initial charge.

The hearing committee recommended revocation of Dr. Miller's staff privileges, the executive committee adopted this recommendation, and Dr. Miller appealed to the hospital board of directors. After an adversary hearing, a committee of directors adopted the recommendation.

At the subsequent trial, Dr. Miller contended that the hospital breached its contract, the medical staff bylaws, by improperly commencing proceedings against him, by providing an inaccurate witness list and by filing an unduly vague list of charges. The Court stated:

> Such de minimis deviations from the provisions of the hospital bylaws are not the sort of impermissible breach contemplated by the Court in *Berberian* [*v. Lancaster Osteopathic Hospital Association,* 395 Pa. 257, 149 A.2d 456 (1959)] when it established the requirement of strict compliance with staff bylaws.[2]

Dr. Miller contended that the findings against him were based entirely on hearsay evidence and were therefore objectionable. The Court, noting that the hospital staff bylaws provided that any relevant evidence shall be admitted if it is the kind of evidence upon which reasonable persons are accustomed to rely even if such evidence would be inadmissible in a court of law, stated:

> Accordingly, in an even less formal hearing before a hospital committee, rules of evidence need not be so stringently applied as in a trial.[3]

Dr. Miller contended that he had been denied his constitutional right to due process. The Court said:

> The actions of public hospitals clearly constitute state action for purposes of Fourteenth Amendment due process. In addition, private hospitals with certain public characteristics, so-called "quasi-public" hospitals, are deemed to be engaged in state action. Appellant asserts that the due process standard must be applied in evaluating the propriety of his dismissal because the Indiana Hospital is a quasi-public hospital.
>
> Our Supreme Court has stated in dicta that there are two categories of quasi-public hospitals: (1) those which receive tax benefits, are funded mainly from public sources, and hold a monopoly in the area they serve, and (2) those which receive construction funds from the federal government under the Hill-Burton Act. The Court relied upon a series of cases from the Fourth Circuit Court of Appeals and one case from the Eastern District of Pennsylvania in formulating the second test of state action. Subsequently, however, in declining to apply the second test, the Third Circuit Court of Appeals has noted that "[t]he majority of circuits have held the receipt of Hill-Burton funds, Medicare and Medicaid payments and the usual hospital licensing provisions do not constitute state action." We therefore conclude that if presented with the issue today, our Supreme Court would not apply the second test of state action articulated in *Adler* [*v. Montefiore Hospital Assn. of Pennsylvania,* 453 Pa. 60 (1973)]. The federal courts look to the specific facts and circumstances of each case in order to determine whether the state is so involved in the affairs of the hospital as to render the action of the hospital that of the state. Similarly, we will employ the first, more fact-sensitive standard articulated by the Court in *Adler* in making our determination.
>
> Appellant alleges that the hospital receives funds under the Hill-Burton Act, as well as from other public sources, and that "there is no denial that Indiana Hospital is the sole hospital in Indiana County and, therefore, holds a monopoly in the area." These bare allegations are insufficient to prove the requisite inextricable relationship between the hospital and the state. Appellant has not made an affirmative showing of the extent of the funds actually received by the hospital from the state and federal governments nor has he adduced sufficient evidence to prove that the hospital holds monopoly status in the region.

---

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*

Accordingly, appellant had not sustained his burden of showing that Indiana Hospital is a quasi-public agency. We cannot conclude on such a record that the action of the hospital in revoking appellant's staff privileges constituted state action so as to call into play the protections of the Federal Constitution. Consequently, we decline to judge appellant's claims of unfairness against the due process clause; rather we will assess these claims according to the standards set forth in the contract between the parties, *i.e.*, the hospital bylaws.[4]

The Court reviewed the various charges of unfairness and concluded:

> . . . the hospital procedure afforded him comprehensive safeguards including: written notice, an opportunity to prepare and to be heard, a right to counsel, a right to present witnesses and to cross-examine, stenographic transcription of the proceedings, and an appeal of right to the board of directors. We therefore conclude that appellant was dismissed in a fair and impartial manner in accordance with the hospital bylaws . . .[5]

In our judgment, this Superior Court decision should comfort physicians who want to expel bad physicians from medical staffs and who have been concerned that they must slavishly follow the rules of procedures as set forth in the medical staff bylaws. The courts apparently will accept reasonable adherence to the bylaws.

Dr. Miller, who maintains a private practice at the Indiana Medical Center, said he will take the case to the state Supreme Court.

1./ ___ Pa. Super. ___, No. 1221 April T, 1978 (April 3, 1980).
2./ *Id.*, slip opin. at p. 5.
3./ *Ibid.*
4./ *Id.* slip opin. pp. 7-9 (footnotes omitted).
5./ *Id.* slip opin. p. 10.

## College of legal medicine forms certification board

The Board of Governors of the American College of Legal Medicine recently elected Cyril H. Wecht, MD, to serve as a member of the newly established American Board of Medicine and Law.

Dr. Wecht is the only Pennsylvanian on the ten-member physician-attorney board. The board will develop national certification examinations for professionals in the combined fields of medicine and law.

Dr. Wecht is editor-in-chief of *Legal Aspects of Medical Practice*, the official monthly publication of the American College of Legal Medicine.

He is director of the Pittsburgh Institute of Legal Medicine .

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# Philadelphia CMS awards Strittmatter gold

Baruch S. Blumberg, MD, receives I.P. Strittmatter Award from Katherine R. Sturgis, MD.

Robert S. Pressman, MD, PMS trustee for the first district, honors Francesco P. DiDio, MD, for 50 years of service in medicine.

Philadelphia County Medical Society presented its I.P. Strittmatter Award to Nobel Prize winning physician Baruch S. Blumberg, MD, PhD. Dr. Blumberg, a resident of Philadelphia, conducted clinical research into the causes of viral hepatitis and cancer of the liver.

He received the Strittmatter gold medal and citation at the society's Awards Night, May 21, 1980 at the PCMS Building, Philadelphia.

In 1976 Dr. Blumberg received the Nobel Prize in Medicine for research which led him to identify an infectious agent, Australia antigen, as the principal case of viral hepatitis and cancer of the liver.

He is an associate director for clinical research and senior member at the Institute for Cancer Research of the Fox Chase Cancer Center. He also is professor of medicine and anthropology at the University of Pennsylvania and he is affiliated with Jeanes Hospital and the Veterans Administration Hospital.

Others honored during the evening were 34 physicians who had provided a half century of service since completing medical school. The 34 received "50 Years of Service Awards."

Also presented at Awards Night were the Benjamin Rush, the Practitioner of the Year, and the Kenneth Appel awards.

The recipient of the individual Benjamin Rush award was Mrs. Arthur L. Cohn for her philanthropic work in the cause of cancer research and fellowships. The organization award was shared by Mercy Hospice and St. John's Hospice for Men.

Benjamin Dickstein, MD, received the Practitioner of the Year award. Dr. Dickstein is a pediatrician from Northeast Philadelphia.

The Kenneth Appel award was made to Wade Berrettini, MD, a third year resident at Thomas Jefferson University Hospital, for his clinical research into blood enzyme activity in paranoid schizophrenia patients.

A new award for service to the community was given to the Philadelphia Flyers for their support of health and medical care in the community.


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# Court narrows scope of Act 111 jurisdiction

**Daniel J. Menniti, PhD, JD**

A Federal Court further defined jurisdiction of the arbitration panels for health care in an order dated January 11, 1980, as Judge Cohill of the U.S. District Court for the Western District of Pennsylvania dismissed a lawsuit because of a lack of jurisdiction.[1]

David A. Firich, a resident of the District of Columbia, sued companies who manufactured, distributed, and sold a cystoscope whose use necessitated surgery on himself. On July 28, 1977, he entered Sewickley Valley Hospital and during a standard medical procedure, the olive tip of the cystoscope disengaged and lodged in his bladder.

The defendants responded to the suit by alleging that negligence on the part of the physician and hospital, jointly or severally, was the proximate cause of the plaintiff's injuries. The defendants alleged that the negligence included improper assembly and improper use of the cystoscope.

The doctor and the hospital requested that the Court dismiss the complaint against them. They argued that the Pennsylvania Health Care Services Malpractice Act deprived the Court of jurisdiction over that part of the case. The Court agreed with them but went further and dismissed the entire lawsuit.

The Court made its decision "only after careful study of the Health Care Services Malpractice Act and federal and state cases arising from the Act." The Act allows a joinder of additional parties, including nonhealth care providers until a panel is selected for a particular case.

The Federal Court, in its review of previous cases, reiterated the fact that a federal court must apply the "substantive law" of the state in which it sits. It concluded that other malpractice suits instituted in federal courts in Pennsylvania were dismissed because the Medical Malpractice Act confers original jurisdiction on the state arbitration panels. Previous cases, however, concerned nonresidents who had made claims against health care providers in Pennsylvania.

*The author is associated with Pepper, Hamilton & Scheetz, legal counsel to the Pennsylvania Medical Society.*

The Court thus had before it a case of the first instance. In the Firich case a plaintiff had sued a nonhealth care provider and the latter had joined health care providers. Section 1301.309 of the Act does provide that the "arbitration panel shall also have jurisdiction to hear and decide any claim asserted against a nonhealth care provider who is made a party defendant with a health care provider."[2] The issue in this case was "whether the state arbitration panel has exclusive jurisdiction over a suit by a patient against nonhealth care providers, in which the defendants have impleaded health care providers."

The reasoning of the Court warrants review since the law is unclear about the present situation. The Court, as stated previously, had no difficulty deciding that Pennsylvania law was to be applied. But to determine its decision in the Firich case it had to go into the legislative history and purpose of the Medical Malpractice Act.

The Court reasoned that the Pennsylvania legislators originally made a broad grant of exclusive jurisdiction to the arbitration panels to minimize physicians' malpractice insurance


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premiums as well as to provide complainants with an efficient system for obtaining redress." "This clearly indicated," said the Court, "an intention on the part of the legislature to have arbitration panels address all cases arising in Pennsylvania that have *at their core* (emphasis added) a claim of medical malpractice."

Moreover, the court stated that, if it did not rule in this way, plaintiffs easily could circumvent the Malpractice Act by filing suit against equipment manufacturers rather than health care providers in cases involving medical equipment use. This could occur under both the Pennsylvania and Federal Rules of Procedure. The arbitration health panels could be bypassed and the cases "would be diverted from the arbitration system because plaintiffs naturally would prefer sympathetic juries to hear their cases."

One interesting aspect of the opinion is the review of case law on the health arbitration panels. One case questioned the weight of "the core" of the original claim to determine whether or not the health arbitration panels had jurisdiction. The Court spoke of the *Staub* case,[3] in which a student claimed for damages sustained in a fall from gymnastics equipment during a physical education class. The school district joined the hospital and two physicians in the suit, alleging negligent delivery of medical services.

The Superior Court, reversing the Court of Common Pleas, ruled that jurisdiction was *not* in the health arbitration panels because the claim "arose from a set of operative facts that had *at its core* (emphasis added) a failure to provide reasonably safe instruction in physical education. The malpractice arbitration panels have no expertise in the issues that such a claim would present."[4] Thus the *Staub* case holds that the Court of Common Pleas may hear a medical malpractice claim in the first instance when the malpractice claim is ancillary to a nonmedical claim and when it is asserted by someone other than the patient.

In its review of other cases, the Court came to the same conclusion, namely, that the courts will permit original, nonpatient defendants to join health care providers as additional defendants when the claim against the original defendant arose from "a set of operative facts that did not involve the delivery of medical services."

The Court, in its review, also looked to the problem of joinder by a defendant in a health arbitration panel, of a defendant not related to the medical field. Specifically, the Court looked at a case involving joinder as allowed by the Act in Section 1301.502.[5]

*Gilette v. Redinger*, 34 Pa. Commonwealth Court 469, 383 A. 2d 1295 (1978), involved a case against various health care providers by the survivors of a decedent who had been struck in the head by a snowball. One of the physician-defendants tried to join the snowball thrower as a defendant in the arbitration hearing. Commonwealth Court affirmed the lower court decision that "non-health care providers" who may be joined in actions before the panels was "intended to encompass those persons who, like manufacturers of drugs or medical instruments . . . are kindred to health care providers."[6]

The Court, in the *Firich* case, thus clarifies the jurisdiction of the arbitration panels as well as compares it with other jurisdictional decisions. The Court noted the backlog of cases but said that that was a problem for the legislature and not the courts.

1./ *David A. Firich v. The American Cystoscope Makers, Inc., American Hospital Supply Corporation, V. Mueller Company, Stuart's Drug and Surgical Supply, Inc. v. Robert W. Doebler, M.D. and Sewickley Valley Hospital*, No. 79-738 (W.D.Pa., filed Jan. 11, 1980).

2./ 40 P.S. 1301.309 (Purdom's Supp. 1979-80).

3./ *Staub v. Southwest Butler County School District*, 398 A. 2d 204 (Pa. Super. 1979).

4./ *Id* at 207.

5./ *Supra*.

6./ *Supra* at 474.


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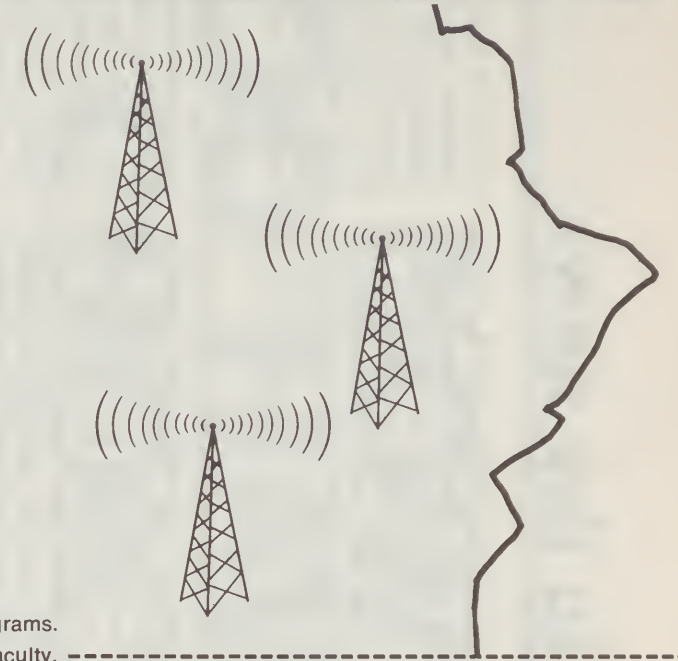

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# physicians in the news

The American Federation for Clinical Research recently awarded its Nellie Westerman Prize for a paper analyzing ethical problems encountered in research with human subjects to two Temple University faculty members. **Mary Moore, MD,** associate professor of medicine in the rheumatology section, and Stephen Berk, PhD, assistant professor of psychology, received the award for their paper on informed consent and giving placebos.

The Commonwealth Board of the Medical College of Pennsylvania recently presented its annual citation to an outstanding Pennsylvania physician to **Mary B. Dratman, MD.** Dr. Dratman is professor of medicine in the endocrinology section at MCP and a medical investigator at the Veterans' Administration Hospital, Philadelphia.

**C. Gene Cayten, MD, MPH,** has been appointed to the AMA's Commission on Emergency Medical Services. He will represent the American Public Health Association.

**James J. Kolenich, MD,** recently was elected president of the board of directors of Emergency Medical Services Council of Northwestern Pennsylvania, Inc. Dr. Kolenich is chief of surgery at Greenville Hospital.

Philadelphia's **Katharine R. Sturgis, MD,** was inducted into the 75th Anniversary Hall of Fame of the American Lung Association on May 21, 1980. Dr. Sturgis, a victim of TB while a senior medical student at Women's Medical College of Pennsylvania, went on to be active in the fight to prevent and control TB.

Philadelphia College of Pharmacy and Science conferred honorary degrees to two physicians at its 159th commencement May 18, 1980. **Lewis W. Bluemle, Jr., MD,** president of Thomas Jefferson University, Philadelphia, and **William Likoff, MD,** president and chief executive officer of Hahnemann Medical College and Hospital of Philadelphia both received honorary Doctor of Science degrees from the college.

**H. Keith H. Brodie, MD,** has been named winner of the 1980 Institute of Pennsylvania Hospital Award in memory of Edward A. Strecker, MD. The award was announced at the annual meeting of the American Psychiatric Association in San Francisco by J. Martin Myers, MD, psychiatrist-in-chief at the institute. Dr. Brodie is professor and chairman of the psychiatry department at Duke University and chief of psychiatry service at Duke Hospital.

**Archibald Laird, MD,** Wellsboro ophthalmologist and a 50-year member of PMS, was a program participant in the 8th Biennial Walter Reed Ophthalmology Graduate Course held at the Walter Reed Army Medical Center, Washington, D.C., April 28-30, 1980.

New officers elected at the annual meeting of the Pennsylvania College of Nuclear Medicine, May 16, 1980 are **Drs. David R. Brill,** president; **Sheldon Baum,** vice president; **Bernard Shapiro,** secretary; **Milton A. Friedlander,** treasurer; and **Oscar M. Powell,** board member at-large.

The Association for Retarded Citizens, Westmoreland recently presented its first Humanitarian Award to **John J. Harper, Jr., MD.** Dr. Harper, chief of pediatrics at Latrobe Area Hospital, started a preschool program for socially and emotionally disturbed children in 1973.

**Abraham J. Twerski, MD,** received an honorary doctor of letters degree at the 134th commencement of Saint Vincent College, May 10, 1980. Dr. Twerski, an orthodox rabbi, is medical director of Gateway Rehabilitation Center, Pittsburgh, and clinical director in the psychiatry department at St. Francis General Hospital.

**Samuel S. Faris, MD,** left, Mrs. Anne Shenberger, and **Arnold Melnick, DO,** display the Child Health Passport. Dr. Faris is a member, Mrs. Shenberger is coordinator, and Dr. Melnick is chairman of the Child Health Passport Drafting Panel, Pennsylvania Committee, International Year of the Child. Dr. Faris was appointed in 1979 as the PMS representative to the panel.

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# Children bearing children: adolescent pregnancy

**Linda E. Feinfeld, MD**
**Marsha Lynn Speller, MD**

*The Bulletin* proclaimed on November 15, 1979 that Philadelphia County had the highest rate of out-of-wedlock births compared with all other counties in Pennsylvania.

Ten thousand out-of-wedlock births were reported (40 percent of all births). Of these, 4,000 were to teenagers, and 151 live births were attributed to girls 15 years old and younger.

**Statistics**

A booklet published in November 1979 by the Community Services Planning Council of Southeastern Pennsylvania entitled *Teenage Childbearing in Philadelphia: Incidences, Service, and Costs* cites the following statistics: "Between the years 1955 and 1977, the number of births to teenagers had doubled in Philadelphia from 10.5 percent of all births to 22.6 percent."

Of the 21 million teens between the ages of 15 and 19 now living in the United States, 10 million are female and an estimated 4.3 million are sexually active. The sexual revolution that is occurring involves from 1 to 2 million teens who have engaged in sexual activity by the age of 14.

The age that teenagers report their first sexual experience is decreasing and the number of sexually active teenagers is increasing. As a result, the number of mothers 15 years and younger is increasing.

One million females between the ages of 15 and 19 years become pregnant every year, and the total number of all births to teenagers equals 20 percent of all births each year in the United States. Of these 1 million pregnancies, 600,000 result in live births, 100,000 miscarry, and 300,000 are aborted.

**High risk pregnancies**

Teenage pregnancies have their effects on both the child mothers and their infants. Two-thirds of these pregnancies are unplanned and the majority of teens do not receive adequate prenatal care.

Dr. Robert Cooke, president of the Medical College of Pennsylvania, reports in his paper, "Planning services and high risk pregnancy," that in childbearing women, in general, the incidence of prematurity increases from 18 percent in the first pregnancy to 22 percent in the second and to 50 percent in the third. Teens have twice as many premature infants as the general population.

Although the maximum fertility time is one year after the onset of menses, and biologically, it is easier for teenagers to conceive, teenage mothers do experience more complications during delivery. Their infants have low birth weights and, during the first year of life, the infant mortality is high. Low infant birth weight is the primary cause of birth defects. Dr. Cooke also reports that 10 percent of the infants born to mothers 15 to 19 years of age have developmental disabilities.

**Toll on child mothers**

Pregnancies during the teenage years take their toll on these young mothers. Eight out of ten teen mothers never complete high school. They usually remain unemployed and depend on public assistance. Thirty to forty percent conceive a second time, and 10 to 20 percent conceive a third time during their teenage years.

In 1977, Philadelphia County reported that for every teenager and her infant, the lifetime cost in care for mother and child was estimated at $20,000 (considered low by many authorities). Nationwide, the total cost for services for the teenage mother and her infant is estimated to be 1 billion dollars per year.

It seems certain that the number of children conceiving and bearing children is not declining in spite of the availability of sexual education and contraception. Although 4 percent of pregnant teenagers conceive as the result of one experience with sexual intercourse, the vast majority of teenagers are not aborting their pregnancies even though abortions are available.

In the past 10 years, there has been a 9 percent increase in the incidence of teenage pregnancy in whites. There

has been no increase in non-whites. This raises the speculation that these pregnancies are not endemic to the poor or poorly-educated racial minorities.

At first glance, the adolescent pregnancy epidemic appears to be the result of relaxed sexual mores and decreasing age of first sexual experience, yet teenagers do not appear to be avoiding the conception "mistake." They are not guarding against future pregnancies. Teenagers, themselves, do not view adolescent pregnancy as a normal event.

**Normal adolescence**

The following review of normal adolescent development is excerpted from the *Handbook of Child Psychiatry,* edited by Noshpitz.

Adolescence is a distinct development period characterized by physiological and psychological upheavals. It is simplistic to describe this age as a normal state of psychological abnormality. It can be viewed as the second major period of individuation and differentiation (the first occurring between ages 2 and 3 years) from emotional dependence on parental figures.

In general, there is a lessening of the early attachments and closeness to family members. The behaviors that often emerge appear to devalue and express insolence toward the parents. This reach for autonomy is necessary to develop and formulate identity and value systems.

In normal adolescence, increasing socialization and identification with peers marked by intense drives (some sexual) make the teenager appear egocentric and inconsiderate. Aggressiveness takes many forms, from the cruel and exploitive to the inquisitive.

Adolescents tend to externalize conflicts, i.e., they see themselves under attack from others, and, as a result, share a comeraderie and feeling of unity against the world. Their search for a common cause to help the oppressed and downtrodden is actually the seed of idealism and patriotism.

The adolescent undergoes a process of critical self-appraisal and gradually acquires a self-concept and self-esteem based on his achievements and failures. He challenges and tests what he has learned to be normal and culturally acceptable. He learns how to cope with anxiety, frustration, guilt, and shame. Depressions due to death of a loved one, sickness, failures, or rejections occur frequently.

Adolescents' thinking and reasoning become more complex. Instead of the overgeneralizations and tendencies to think that their feelings are unique, adolescents begin to give way to deductive reasoning and thinking through problems. The adolescent becomes less egocentric. He starts to empathize. Anxiety over issues of adequacy and competence lessens as the adolescent becomes more preoccupied with planning for the future. Realistic attitudes about current potential follow such development.

During these developmental stages, new roles are significant. School is a major focus of work activities and, concommitantly, has a major influence on values and attitudes. The adolescent's high ideals and wishes for perfection in himself are likely to be confronted by a strong and dismaying sense of inadequancy.

During this time, young people begin to see themselves as sexual beings and to develop intimate relationships with the opposite sex. "Crushes" or eroticized relationships are common. Sexual attachments occur outside the family and reinforce the need for separation from the family. Sexual fantasies and daydreaming are common.

---

*The authors are assistant clinical professors in the division of child, adolescent, and family psychiatry, department of psychiatry and human behavior, at Jefferson Medical College. This is the eighth article prepared under the supervision of Thomas Wolman, MD, and the department of psychiatry at Jefferson as part of the series on office counseling for primary care physicians. The series is a project of the departments of psychiatry of the state's seven medical schools in cooperation with the Pennsylvania Psychiatric Society.*

With so many physical and psychological changes occurring during the adolescent years, it is not unusual that adults tend to note only the chaos and turmoil of this period. Much unfinished psychological development from earlier periods also is being exacerbated and fixed in the adolescent personality. The psyche is accommodating the many physical changes and a new body self-image.

**Etiology**

The occurrence of pregnancy in teenagers is not new throughout world cultures, particularly in societies where it marks the emergence of the child into the adult community of power and responsibility. But it is of concern in the American culture which encourages a lengthy childhood. Adolescence is the extreme end of that childhood. In *Psychiatry in the United States,* pregnancy during childhood is viewed as a sexual disturbance. It is categorized by Dr. Adrian Copeland as follows: non-pathological pregnancy related to curiosity and inexperience; cultural, an accepted subcultural norm; and pathological pregnancy, a reflection of emotional problems and psychiatric disorder.

Factors which seem to influence the increased incidence of adolescent pregnancy are family disintegration, maternal deprivation, and sibling order (the majority being oldest siblings). Also, pregnancy seems to be an etiologic cause of teenage marriages: one-third of these marriages occur after pregnancy, and three out of five break up within six years.

One-third of all teenagers do not live in a family unit with both a mother and a father. In these units, parents may be divorced, deceased, or absent for other reasons.

Pregnancy, resulting in either a live birth or abortion, is the most often cited reason for teenagers' dropping out of school.

In the pathological group, many pregnant teenagers live in an abnormal environment where children are being raised by persons unable to function as parents. This absence of

adequate family life can be seen as a continuum ranging from neglect through deprivation to abuse. We will discuss the extreme end of this spectrum in order to highlight the effects of the world of abnormal rearing upon the developing female.

### Abnormal rearing

The abused female child experiences an impairment in her adult sexual growth and parenting ability. Often she is subjected to the abnormal rearing practices that were commonly part of her parents' childhood experiences. These girls perpetuate the same patterns in subsequent generations.

The abused girl, on reaching puberty, has a strong desire to become pregnant. She will refuse birth control and dismiss abortion. Conception, when it occurs, often leads to a wanted pregnancy. Pregnancy resolves the girl's special problem; it provides her escape from an unhappy home experience. The infant then functions as comfort and company for her in her loneliness.

The abused child who is now an adolescent mother has not learned how to trust others. She lacks confidence in others and believes she must learn to deal with her own problems by herself.

Distrust leads to isolation and denigration of her self-image. This adolescent becomes convinced that she is no good. Because of these attitudes, friendships, school experiences, and mate selection are in jeopardy and most often disastrous.

The abused child is most often a parentified child who must take care of mom and dad when they have problems. Chances are, this adolescent's infant also will be parentified and become the object of unrealistic expectations. The infant may be scapegoated, chastised, belittled, and neglected.

The abused child who becomes a mother during adolescence has a gap in her childhood known as a childhood lost. She has spent so much time trying to meet the needs of her parents that large segments of normal childhood are relinquished. In not being allowed to experience many normal developmental happenings, and in being required to spend much more time role-reversing and complying, she misses much of the most helpful learning processes necessary in becoming a parent, i.e., childhood. Experiencing childhood is a major prerequisite to parenting. Being treated as a child, having the chance to develop trusting relationships, learning the skills of establishing friendships, and feeling good about one's self are some of the necessary ingredients. The abused child, pregnant during adolescence, is about to begin to perpetuate her own abnormal rearing.

### Sibling order

Sibling order has been demonstrated to be related to the incidence of adolescent pregnancy. From clinical practice, we have seen that the older female child is most often the parentified child. Another clinical phenomenon related to this is that often, the teenager with multiple pregnancies during adolescence appears to reach a life adjustment crisis just as her last child approaches toddler stage. The adolescent mother often will leave her children in foster care or with other family members and become promiscuous. We speculate that this occurs most readily when the children of these mothers are developmentally disabled and unable to be parentified, and the need for special care for her children becomes an overwhelming burden for the adolescent mother.

### Conclusions

In America, pregnancy is not normal to adolescent development. Therefore, when interviewing the pregnant teenager we look for the presence of psychiatric illnesses, pathological relationships with parents, attempts to solve the problems of rejection and neglect, or attempts at recognition and respect through maternal status.

The pregnant teenager often feels isolated emotionally from her family and peers. In these cases, abortion is no solution. The teenager views abortion as a further rejection. It may lead to greater problems than the prospective childbirth, namely, depression and suicide.

The non-psychiatrist should bear in mind that adolescent pregnancy is culturally premature. In all cases, the normal issues of adolescence—identity, autonomy, and individuation—should be addressed. Request a psychiatric consultation, when you sense an emotional problem.

The pregnancy need not be unintentional, but rather a coping device to adjust to the changes of adolescence or the traumatic experience of an abnormal family environment. To treat what we see as a problem, we must realize that this problem often seems the solution to the adolescent.

### REFERENCES


1. **Settlage, D.S.F., Baroff, S., Cooper, D.:** Sexual experience of younger teenage girls seeking contraceptive assistance for the first time. *Family Planning Perspectives 5:*233, 1973.
2. **Settlage, D.S.F., et al.,** 1973, op cit; and **Kantner, J.F., Zelnik, M.:** Sexual experience of young unmarried women in the United States. *Family Planning Perspectives 4:*4, 1972.
3. **Furstenberg, F., Jr., Gordis, L., Markowitz, M.:** Birth control knowledge and attitudes among unmarried pregnant adolescents: a preliminary report. *Journal of Marriage and the Family 31:*34, 1969.
4. **Reichelt, P.A., Werley, H.H.:** Contraception, abortion and venereal disease: teenagers' knowledge and the effect of education. *Family Planning Perspectives 7:*83, 1975.
5. **Offer, D., Offer, J.:** Normal adolescence in perspective. In *Current Issues in Adolescent Psychiatry,* J. Schoolar, ed. Brunner/Mazel, New York, 1973.
6. **Thomas, A., Chess, S.:** Evolution of behavior disorders into adolescence. *Amer J Psychiat* (in press).
7. **Thomas, A. et al.** *Behavioral Individuality in Early Childhood.* New York University Press, New York, 1963.

Case report

# Inorganic mercury overexposure

Jan Lieben, MD, MPH

Occupational mercury poisoning has been described by Agricola, Paracelsus, Ramazzini and many others. The adverse effects of mercury intake include: gingivitis, stomatitis, excess salivation, a metallic taste, erethism (a peculiar form of emotional instability), pneumonitis, bronchitis, chest pains, dyspnea, coughing, irritation, corrosion of body tissues contacted, abdominal pain, diarrhea, sudden death, and circulatory collapse.

Chronic exposure may result in tremor, irritability, outbursts of temper, shyness, headache, fatigue, dysarthria, ataxia, constricted visual fields, and involuntary movements. Signs of kidney damage, such as proteinuria, casts in the urine, edema, oliguria, and renal failure also may result.

Mercury can be absorbed through the skin, the gastrointestinal tract, and the lungs. The principal source of occupational mercury poisoning is elemental mercury vapor. Exposure to mercury compounds occurs less frequently.[1]

Mercury is excreted by the kidneys. Other sources of excreted mercury are the bile of the liver, the intestinal mucosa, the sweat glands, and the salivary glands. Mercury also may be excreted through the lungs, hair, nails, feces, and skin.[2,3]

### Mercury excretion

The principal route of mercury excretion from the body is through the urine and, to a lesser extent, through the feces. The kidneys are the critical organs regulating excretion of mercury. Occasionally nephrosis follows occupational exposure or ingestion. Urinary mercury is used as a guide to measure absorption and body burden in the occupationally exposed.

Gage has shown that renal excretion of mercury involves two phases: the removal of mercury from the blood and its accumulation in the renal tissue, predominantly the renal tubular cells; and the net excretion of mercury into the urine (elimination).[4]

The two processes do not proceed uniformly or synchronously in intermittent exposures; maximal excretion is delayed until the kidneys have accumulated a certain burden. This delay may result in peak excretions during periods of nonexposure. Some accumulated mercury liberated from cell proteins of critical organs continues to be excreted after cessation of exposure.

Measuring mercury in the urine has been the principal method for estimating absorption and excretion. The amount excreted by other routes may account for the disparity between the extent of exposure and the amount in the urine.

Bidstrup, et al[5] in their investigation of workers exposed to inorganic mercury found that the urinary mercury was increased both in men suffering from chronic mercurialism and also in those exposed, but not showing any signs or symptoms of poisoning. Both groups excreted more than 300 $\mu$g/l daily, but some of those with definite symptoms had a urinary level up to 4,000 $\mu$g/l.

In general, with high urinary mercury levels above 100–200 $\mu g$, the incidence of symptoms and signs of mercury poisoning described above increases, although cases up to 300 $\mu$g/l without symptoms have been described.[6]

An occasional patient with relatively low urinary mercury may have many symptoms compatible with excessive mercury exposure (see case 1 below). Since the symptoms of mercury poisoning are common to those of other diseases without any mercury exposure, mercury poisoning is difficult to distinguish. Given mercury overexposure and urinary findings, we are compelled to recommend that patients with symptoms be removed from additional exposure and treated.

The blood mercury determination is less help than the urinary, since it is more susceptible to individual fluctuation than the mercury in the urine. We must rely on a history of symptoms and environmental measurements. These measurements must include more than the phrase, "works with mercury," which frequently is all that is said, with no additional information available.

Environmental exposure data are more valid than urine and blood values and are more valuable in establishing the diagnosis.

The 1973 Criteria Document, Occupational Exposure to Inorganic Mercury, of the National Institute of Occupational Safety and Health recommends that workers not be exposed to an inorganic mercury concentration greater than 0.05 mg of mercury per cubic meter, as a time weighted average exposure (TWA) for an eight hour work day.[7]

The three patients under study include a thermometer filler and two dental technologists. Although overexposure in dentistry has been described before,[9] the hazard has increased as the practice of dentistry has undergone changes which increase the possibility of exposure.

Both technologists worked in busy dental practices. In these practices, as many as 50 cavities are filled per day by dental technologists. Dentists drill and clean out the cavities and dental technologists fill the prepared cavities with amalgam, an alloy of silver and

*Dr. Lieben is professor of occupational medicine in the community health and preventive medicine department of Thomas Jefferson University.*

**TABLE 1**
**Micrograms of Mercury per Liter of Urine**

| Dental Personnel | | Controls | |
|---|---|---|---|
| 12/3/76 | 12/17/76 | 12/3/76 | 12/17/76 |
| 1. 30 | 39 | 10 | 15 |
| 2. 40 | 41 | 12.5 | — |
| 3. 45 | 104 | 10 | — |
| 4. 65 | 18 | 15 | 12 |
| 5. 50 | 104 | 13 | 8.5 |
| 6. 72 | 54 | 10 | — |
| 7. — | 82 | — | — |

tin dissolved in mercury.

When first prepared, amalgam is elastic, but after a few hours it sets to a hard mass. An amalgam of gold, copper, and zinc is used for gold fillings.[9] Both technologists stated that the preparation of the amalgam in their working environment was hurried and that there were frequent spills and contamination.

**Case 1**

A 46-year-old female employed as a dental technologist for four years developed a series of vesicles in the palms of her hands in February 1976. She was treated with steroids and antihistamines. The condition cleared up with treatment and removal from exposure. She also complained of generalized pruritus, hyperactivity and tiredness, muscle aches, diarrhea, and abdominal cramps, off and on, for a period of six months.

She returned to her work in the dental office on March 19, 1976 and after two days the vesicles returned. She came to me on November 22, 1976 after she had returned to work using surgical gloves. She complained of nervousness, shyness, short-temperedness, tingling in fingers, difficulties in her home life, fear of falling, and a 20 lb. weight gain.

Between my seeing her in November and her initial dermatitis, the patient was treated at a local hospital for hyperthyroidism. Her mercury urine level on August 4, 1976 was 43 $\mu$g and on September 24, 1976 was 100 $\mu$g.

In view of her persistent symptoms and her mercury level of 100 $\mu$g, we recommended that she not return to any mercury exposure. This recommendation was made in spite of the relatively low urinary mercury levels, primarily because environmental mercury levels in the dental clinic were high, namely, twice the NIOSH recommended limit in several locations.

As a result of this case and because of the high environmental levels, samples for urinary mercury were collected from seven other employes of the dental clinic and from six controls at two week intervals. The results of the sampling appear in Table 1.

Other employes of the dental clinic had no complaints, despite the fact that two had mercury levels slightly higher than those of Case 1. The clinic was decontaminated thoroughly and no further complaints were registered.

**Case 2**

A 30-year-old female dental assistant for four years was employed in a similar clinic and filled predrilled teeth. Her past history was noncontributory, except that in November 1976 she had complained of a metallic taste in her mouth and at that time, her urinary mercury level in a 24 hour specimen was 95 $\mu$g. She had no other symptoms and resumed her work after a short absence. No other data were available.

On September 20, 1978 she saw her physician and complained of loss of hair. Again she had no other symptoms. On September 22 her urinary mercury was 285 $\mu$g/l, on October 20, 1978, 206 $\mu$g/l, and on October 29, 1978, it was 122 $\mu$g/l. On the advice of her physician she stopped working in the clinic.

She was examined on November 9, 1978, at which time she had no complaints other than her hair loss. No personality change nor cranial, peripheral nerve abnormality was noted. Her vision was normal. There were no tremors and she denied gastrointestinal and urinary problems. She complained of a mild hearing loss, which was corroborated by an audiometryc examination. She stated that her hearing loss had been present prior to her mercury exposure. Two chem-screens and blood counts on September 20, 1978 and again on November 9, 1978 were in the normal range, except for a mildly elevated potassium of 5.40 (normal range 3.40–5.20).

Recommendations for air sampling and examination of her six co-workers were made. She was followed with biweekly urinary mercury examinations.

**Case 3**

This 50-year-old female was seen on May 18, 1978 in reference to her insurance claim. She had worked for a thermometer manufacturer as a glass blower and thermometer filler from May 1975 to July 1976. Her history revealed that she had had three pregnancies, a prolapsed uterus, and at age 37 a hysterectomy.

She stated that the operation of the plant and the handling of mercury was careless. Frequently she found mercury on her clothing when she came home from work. In July 1976 she became ill with dermatitis of the face and neck, between her breasts, and around her waist; she also had symptoms of backache and increased frequency of urination.

While she was still at work, her urine mercury level on January 26, 1976 was 188 $\mu$g/l; on August 9, 1976 following termination of employment it was 115 $\mu$g/l; and 80 $\mu$g/l on October 7, 1976. At the time of examination, almost two years later, her mercury level was 3 $\mu$g/l and her chem-screen and complete blood count were within normal limits.

The dermatological symptoms cleared up shortly after she left employment; however, her urinary symptoms have recurred on several occasions. She was seen by a urologist. Cystoscopy and intravenous urogram both were normal. She was diagnosed as having recurrent cystitis.

**Discussion**

The overexposures were not severe. A follow-up call to the first patient revealed that she has not returned to work and is suing her employer for disability payments. She would not

provide further information in view of her lawsuit.

The second patient continues to do well. Her urinary mercury level had decreased to 40 μg/l on January 4, 1979. She had decided to seek employment in a mercury-free environment.

The third patient, seen at the request of her employer's insurer, had a mercury level down to 3 μg/l. She still was having occasional exacerbations of her chronic cystitis.

All three cases were exposed in environments where mercury was handled in a careless manner; environmental measurements exceeding the present OSHA standard of 0.1 μg per cubic meter of air (and the 0.05 mg per cubic meter suggested by NIOSH) were obtained in two of the three work locations. Urinary excretion varied. All levels of excretion returned to "within normal limits" following removal from exposure.

The symptoms in the three cases were not specific, nor were they uniform. There were confounding factors in the first and second patients who had abnormal thyroid conditions or a preexisting genitourinary condition.

Dermatitis in both these cases seemed occupational since it improved following removal from exposure and returned following resumption of duties.

Another factor was introduced by the laboratory which does most of the mercury determinations in the Philadelphia area and secondarily by the treating physicians. All mercury level reports were accompanied by the annotation, *"normal less than 20 μg/l urine"*, meaning non-exposed persons.

The generally accepted biological standard for those occupationally exposed is 100–150 μg/l.[10] The laboratory had not been informed that in these three cases, occupational exposure, rather than a general differential diagnosis, was the issue. Thus, it became partially responsible for the physicians' diagnosis of "severe mercury poisoning" in these cases. The physicians in turn did not check the literature for the biological levels associated with the various circumstances of mercury absorption, which is rarely encountered in their practice.

This matter has been discussed with management of the laboratory and the annotation of reports will henceforth routinely include the additional comment, *"occupational threshold–100 μg/l urine"* if the urinary mercury level found by the laboratory is 20 μg/l or greater.

## REFERENCES


1. **Bidstrup, P.L.:** *Toxicity of Mercury and Its Compounds.* Elsevier Publishing Company, New York, 1964.
2. **Magos, L.:** Factors affecting the distribution of mercury and its compounds between different organs. Working paper for the *Symposium on MAC Values,* Stockholm, November 1968.
3. **Swenson, A., Lundgren, K.D., Lindstrom, O.:** Distribution and excretion of mercury compounds after a single injection. *Arch Indust Hlth 20:*432–43, 1959.
4. **Gage, J.C.:** The distribution and excretion of inhaled mercury vapour. *Brit J Indust Med 18:*287–94, 1961.
5. **Bidstrup, P.L., Bonnell, J.A., Harvey, D.G.:** Chronic mercury poisoning in men repairing direct current meters. *Lancet 2:*856–61, 1951.
6. **West, I., Lim, J.:** Mercury poisoning among workers in California's mercury mills—A preliminary report. *JOM 10:*697–701, 1968.
7. *Exposure to Inorganic Mercury.* U.S. Dept. of Health, Education and Welfare, Public Health Service, NIOSH, 1973.
8. **Mantyla, G., Wright, O.D.:** Mercury toxicity in the dental office. *J Am Dent Assn 92:*1189–1194, 1976.
9. **Hunter, D.:** *The Diseases of Occupations.* Little, Brown and Co., Boston, 1955, p. 256–57.
10. **Clayton, G.D., Patty, F.E.:** *Industrial Hygiene and Toxicology,* Biological threshold values, John Wiley and Sons, New York, 1978, p. 765.



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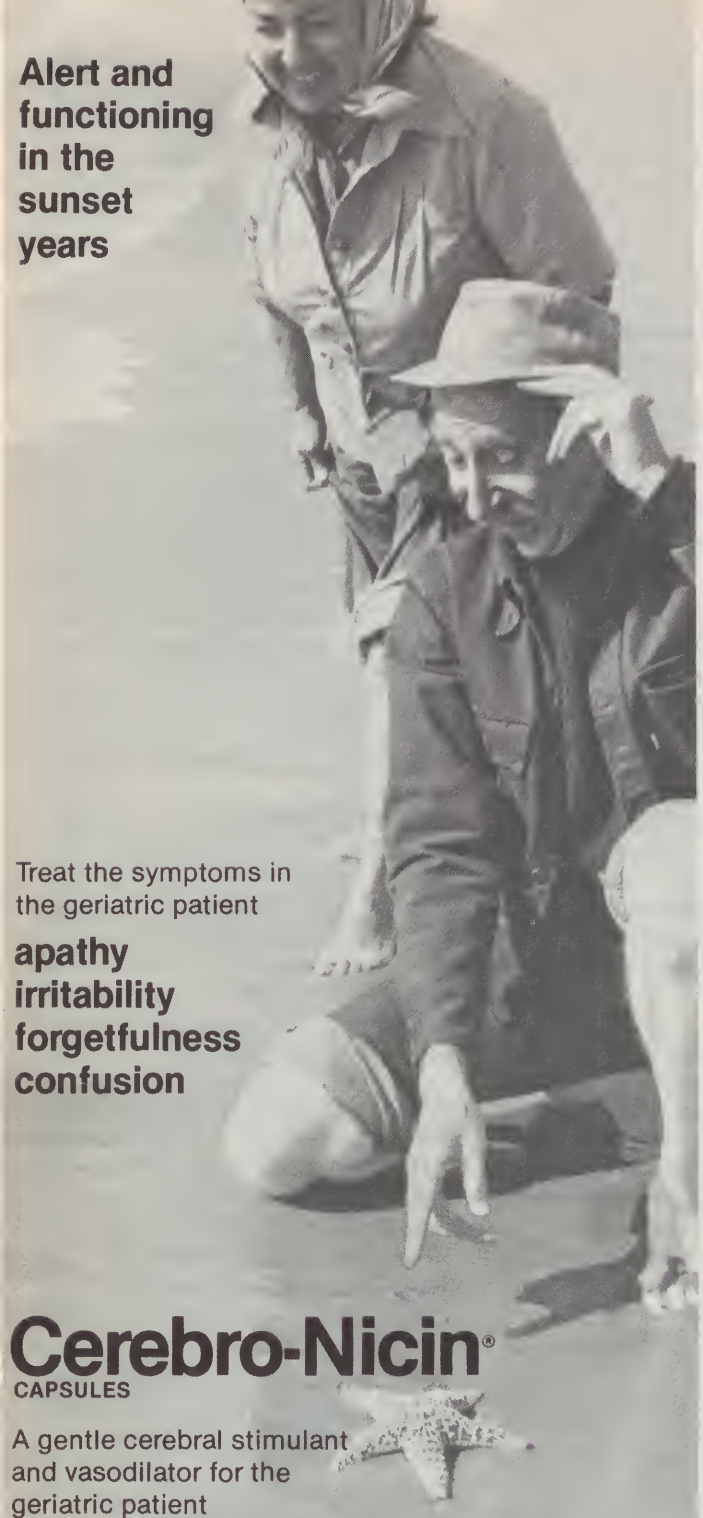

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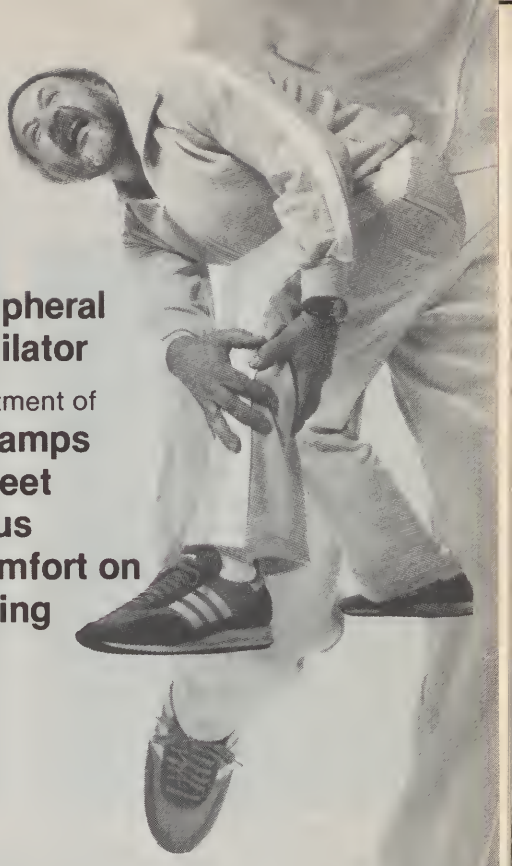

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Dr. Dersh was elected to a one-year term. He succeeds Eugene B. Rex, MD, Philadelphia ear, nose, and throat physician.

Donald B. Kamerer, MD, Pittsburgh otolaryngologist, was elected president-elect to take office in 1981. Presently serving as secretary, Dr. Kamerer will continue in that post until he assumes the presidency.

Elected to vice presidencies were Drs. William H. Annesley, Jr., Philadelphia ophthalmologist, first; John M. Penta, Reading otolaryngologist, second; and John F. Connole, Altoona ophthalmologist, third.

William K. Grove, MD, York ophthalmologist, was re-elected treasurer. Also re-elected were Drs. Thomas B. Souders, West Reading ophthalmologist, editor of *Transactions,* official journal of the academy and Donald T. Burns, Wyomissing ophthalmologist, secretary for instruction.

The academy presented its Distinguished Service Award to Silvio H. DeBlasio, MD, chief of otolaryngology and senior staff member at Allegheny Valley Hospital.

## Clinical problem solving course for internists at NYU

New York University Post-Graduate Medical School will offer a continuing medical education series for physicians practicing internal medicine. The clinical problem solving course, Consultations in Internal Medicine, will meet Wednesdays from October 10 through December 17.

The objective is to analyze, systematically, a series of patient management problems commonly encountered in office and hospital practice. Diagnostic and therapeutic dilemmas presenting in ambulatory settings will receive special attention.

The ten weekly workshop sessions are accredited for 30 AMA Category I credit hours and 30 AAFP prescribed credit hours (pending). Course tuition is $395.

For further information write New York University Post-Graduate Medical School, Registration Department, LHB, 550 First Avenue, New York, NY 10016, or telephone (212) 679-8745 (24-hour service).

## State internists install Dr. Hillyer as president

Peter N. Hillyer, MD, of Devon, was installed as president of the Pennsylvania Society of Internal Medicine at its annual meeting, May 14, 1980. Dr. Hillyer succeeded Robert Kough, MD, of Danville.

Dr. Hillyer is in private practice in Paoli. He is an advisor for internal medicine to medicare, Blue Shield, and PMS. Recently he was elected a member of the corporation of Blue Shield of Pennsylvania.

He graduated from Williams College and the University of Rochester School of Medicine and continued his training in internal medicine at Boston City Hospital. At Temple University, he completed a fellowship in hypertension and renal disease and was a member of the faculty until 1970.

He is now on the staff at Paoli Memorial Hospital where he serves as chairman of the research and education committee and on the executive committee.

DR. DERSH

DR. DeBLASIO

# PMS jail health program involves 22 facilities

**Arnold W. Cushner**

Drug and alcohol addiction, venereal disease, TB, and diabetes are just some of the medical problems locked up with the inmates of many county jails. But these problems have not gone unnoticed by organized medicine.

Since 1972, the American Medical Association (AMA), through a grant from the federal Law Enforcement Assistance Administration, has been involved in a nationwide program to improve jail health care.

### State physicians involved

For almost two years, the Pennsylvania Medical Society has participated in the AMA's program. An advisory committee of state physicians directs the operations of the program.

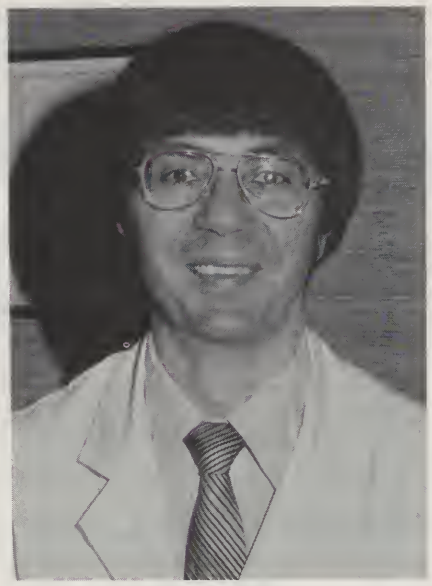
Committee members are James J. Houser, MD, chairman, Franklin; James A. Collins, Jr., MD, Geisinger Medical Center; Theodore L. Yarboro, MD, Sharon; John Belfonti, Bureau of Corrections; Major John Kase, Pennsylvania Prison Society; Gladys Keiper, RN, Pennsylvania Department of Health; and Walter G. Scheipe, warden, Berks County Prison.

During its second year in the program, PMS is surveying the health care facilities at 14 county jails and assisting these jails to meet standards established by the AMA.

The counties involved are Allegheny, Berks, Columbia, Cumberland, Dauphin, Erie, Huntingdon, Juniata, Lancaster, Lebanon, Luzerne, Mercer, Northampton, and York. These counties accepted invitations from PMS to participate in the jail health care program.

Last year, PMS provided assistance to jails in Bucks, Delaware, Franklin, Lehigh, Lycoming, Monroe, Montgomery, and Montour counties.

The goal of each of these county jails is to bring its facility into conformity with the AMA-set standards. The PMS program makes jail officials aware of how their facilities presently measure up to these standards and offers technical assistance for improvements.



DR. HOUSER

DR. YARBORO

### Jail visits

Through a series of three visits to each of the county facilities PMS Special Projects Assistant, Christina Reese helps jail officials identify the facility's objectives. The list of AMA standards is reviewed to determine what changes or additions to procedures are necessary to meet the standards.

The AMA standards cover all aspects of health care: administration, personnel, care and treatment, drugs, health records, and medical-legal matters.

After the initial visit the warden receives a letter from PMS indicating those requirements which still have to be fulfilled in order to meet AMA standards and suggesting ways these may be met.

### Written policies

During the second visit, the written policies covering inmate care are examined.

The facility must have a written policy requiring that at least one health trained correctional officer per shift is trained in basic cardiopulmonary resuscitation (CPR) and can recognize symptoms of illnesses most common to inmates.

Dealing with the drug and alcohol problems of inmates when they are admitted is another area that requires written policy and procedures.

"Detoxification of drug or alcohol dependent inmates is vital to the health of the inmate and to the safety of the prison population as a whole," explains Dr. Yarboro, committee member and himself a physician for Mercer County jail. "But detoxification is not an amateur operation. Psychotics, seizure-prone individuals, pregnant women, juveniles, and the elderly all are special risks. Consequently, all of these require special attention. Detoxification, if it is performed at the facility, should be done under a doctor's supervision, and we look for the prison's written policy to reflect this fact."

"Written policies are important," says Dr. Yarboro, "if health care is to be administered routinely rather than on a crisis basis."

As after the first visit, the official at the facility receives a detailed letter offering technical assistance for fulfilling the requirements that still remain unmet.

The final visit is the occasion for a survey to determine the facility's level of compliance with the AMA stan-

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*The author is on the staff of the PMS Communications Division.*

dards. The survey findings are forwarded to the AMA Accreditation Committee which assesses the jail's improvement and decides whether to extend accreditation.

The AMA has 69 standards. To be accredited for one year, the facility must meet 23 standards designated as "essential," and 70 percent of the remaining standards. For two year accreditation, the jail must meet the essential standards, and 85 percent of the remaining ones. Bucks, Delaware, and Montgomery counties received accreditation last year.

**Problems**

A facility may not have a physician who comes to the jail on a regular basis. One of the essential AMA requirements is that the facility have a designated health authority. This authority must either be a physician, or if it is someone who is not a physician, all final medical decisions must be cleared with a physician.

Another problem is that some facilities do not do a health screening on inmates as they arrive.

Dr. Yarboro says, "The importance of a health screening cannot be overemphasized. Inmates frequently arrive at jail with various infectious diseases, with alcohol or drug problems, or just in poor general health. Only by screening all prisoners as they arrive can we see to it that sick inmates receive proper and immediate medical attention. Screening also may prevent infected inmates from spreading their illnesses to other prisoners.

A third problem is the lack of written health care procedures for distributing medication, conducting daily sick call, or administering first aid in emergency situations such as attempted suicide.

**Why accreditation**

There are both humane and practical reasons for seeking accreditation according to James J. Houser, MD, chairman of the Advisory Committee on Jail Health Care.

"The whole facility, of course, benefits from having a healthy population," he says. "Health problems that are not attended to spill over and can affect the smooth operation of any institution, but particularly a prison facility. This can be prevented by having proper health procedures and treatments and it can make the job of prison officials considerably more manageable.

"Being accredited also can offer certain legal protection to county facilities. In recent years, many jails have been sued for failure to provide adequate health care. The trend of court decisions in these cases has been to view favorably those institutions which have improved their health care delivery. Seeking accreditation demonstrates the jail's efforts in improving."

"But perhaps the most compelling reason for upgrading jail health facilities," says Dr. Houser, "is that no community can afford to ignore inmate health care. The illness of a prisoner is a threat not only to the inmate himself and the entire prison population, but it is a threat to the whole community. Since many county jail inmates are there only a short time, exposure to contagious diseases can endanger the whole community once a sick inmate is released."


## Institute for Medical Education and Research

### Geisinger Medical Center

### 1980-1981 Continuing Education Programs

**Annual Rheumatology Seminar**/Wednesday, September 10, 1980/9 a.m. to 5 p.m./$55

**Poison Update**/Tuesday, September 23, 1980/9 a.m. to 5 p.m.

**Practical Solutions to Common Problems in Family Medicine**/Wednesday, September 17, 1980/1 p.m. to 5 p.m./$30

**Management of Acute Neurological Problems**/Wednesday, October 1, 1980/9 a.m. to 5 p.m./$55

**I.V. Therapy Program**/Wednesday, October 8, 1980/9 a.m. to 5 p.m.

**Gastrointestinal Disease: Update on Diagnostic & Surgical Techniques**/Wednesday, October 15, 1980/9 a.m. to 5 p.m./$55

**6th Annual Emergency Medicine Seminar**/Wednesday, October 22, 1980/9 a.m. to 5 p.m./$55

**Common Problems, Challenging Cases, and Frequent Pitfalls in Allergy**/Wednesday, October 29, 1980/9 a.m. to 5 p.m./$55

**Advances in Pediatrics**/Thursday, November 13, 1980/9 a.m. to 5 p.m./$55

**Critical Care Medicine-1980***/Friday, Saturday, & Sunday, November 14-16, 1980

**Concepts in Clinical Practice***/Friday, Saturday, & Sunday, February 13-15, 1981

**Current Dental Procedures**/Wednesday, February 25, 1981/9 a.m. to 5 p.m.

**Venereal Disease Update**/Wednesday, March 4, 1981/1 p.m. to 5 p.m./$30

**Otolaryngology Update for Primary Care Physicians**/Wednesday, March 18, 1981/9 a.m. to 5 p.m./$55

**Occupational Health Nurse Program***/Saturday, March 28, 1981/9 a.m. to 5 p.m.

**Current Concepts in the Rehabilitation of the Stroke Patient**/Wednesday, April 1, 1981/9 a.m. to 5 p.m./$55

**Problems in Neuro-Ophthalmology***/Saturday, April 11, 1981/9 a.m. to 1 p.m./$30

**Advances in Practical Dermatology**/Wednesday, April 15, 1981/9 a.m. to 5 p.m./$55

**Problems in Vascular Disease**/Wednesday, April 22, 1981/9 a.m. to 5 p.m./$55

**Gynecology Update for Family Practitioners**/Wednesday, April 29, 1981/9 a.m. to 5 p.m./$55

**13th Annual Special Child Conference***/Saturday, May 2, 1981/9 a.m. to 1 p.m.

**2nd Geisinger Nutrition Symposium***/Friday & Saturday, May 15-16, 1981

**Thyroid Disease Update: 1981***/Saturday & Sunday, May 30-31, 1981/Pocono Hershey

**Congestive Heart Failure:** Reversible Causes and Management/Wednesday, June 10, 1981/9 a.m. to 5 p.m./$55

**Annual Pocono Course***/Wednesday to Sunday, August 12-16, 1981

**Weekend course*

As an organization accredited for continuing medical education, Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. (Refer to each program: full day, 7 hours credit; half day, 4 hours credit.)

**For further information write to Millie K. Fleetwood, Ph.D., Geisinger Medical Center, Danville, PA 17821 or telephone (717) 275-6925.**

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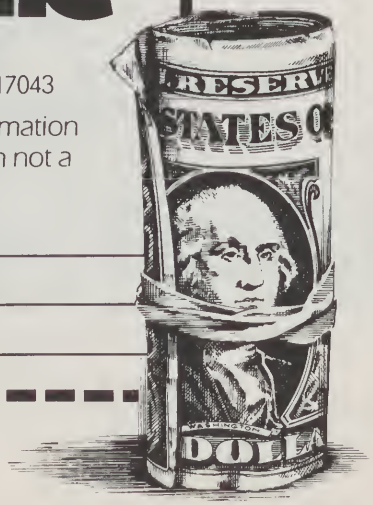


# obituaries

• *Indicates PMS membership at time of death*

• **Mila J. Ashodian,** Narberth; 1950; age 75, died January 9, 1980.

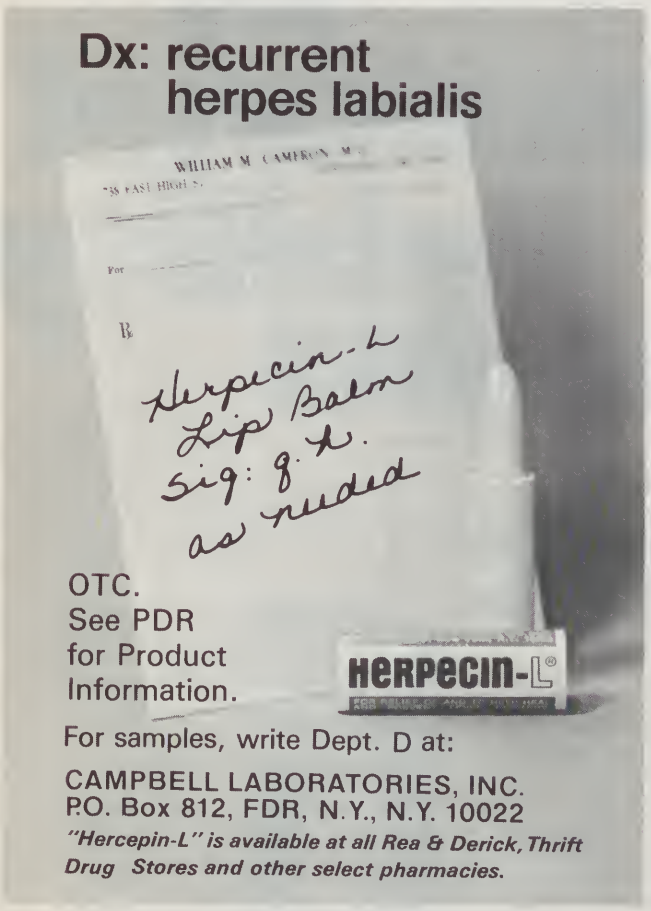
• **Raymond William Brust,** Havertown; University of Pennsylvania School of Medicine, 1927; age 80, died 1980.

• **John Holmes Davie,** Philadelphia; Hahnemann Medical College, 1933; age 73, died February 20, 1980.

• **Ernest J. Dewees,** Falmouth, Massachusetts; University of Pennsylvania School of Medicine, 1918; age 90, died April 24, 1980.

• **Thomas Gerard Dineen,** Lansdowne; Jefferson Medical College, 1942; age 63, died May 1, 1980. Dr. Dineen practiced internal medicine in Philadelphia and Delaware counties for 33 years. He was on the staff of Mercy Catholic Medical Center.

• **Theodore Oscar Doyle, Sr.,** Harrisburg; University of Pennsylvania School of Medicine, 1938; age 74, died May 19, 1980. Dr. Doyle was on the staffs of Harrisburg and Holy Spirit hospitals.



• **William Robert Eaton,** Pittsburgh; University of Maryland School of Medicine, 1943; age 65, died May 7, 1980. Dr. Eaton was an orthopedic surgeon in Shadyside for more than 35 years. He was on staffs of Allegheny General and Divine Providence hospitals and the Home for Crippled Children.

• **John Adam Focht,** Wernersville; Hahnemann Medical College, 1930; age 75, died May 21, 1980. Dr. Focht was Berks County coroner for 15 years and in January 1980 received recognition for 50 years of practice.

• **James H. Foy;** Scranton; Jefferson Medical College, 1930; age 77, died May 8, 1980. Dr. Foy practiced in Scranton for more than 50 years.

• **Paul Earle Gordon,** Tamarac, Florida; Temple University School of Medicine, 1939; age 66, died April 3, 1980.

• **Jacob C. Lerner,** Philadelphia; Temple University School of Medicine, 1923; age 77, died March 8, 1980.

• **Robert A. McDaniel,** Baltimore, Maryland; Howard University College of Medicine, 1910; age 96, died March 1980. Dr. McDaniel was the oldest practicing physician in Fayette County and the oldest member of the Fayette County Medical Society having joined it in 1917. He was the first black member of the society.

• **Russel F. Miller,** Philadelphia; University of Pennsylvania School of Medicine, 1926; age 79, died May 6, 1980. Dr. Miller was associate professor of radiology at the University of Pennsylvania and professor of radiology at the now-closed Philadelphia General Hospital.

• **Joseph V. Missett, Jr.,** Philadelphia; University of Pennsylvania School of Medicine, 1927; age 78, died March 2, 1980.

• **Zenon F. Novicki,** Philadelphia; Jefferson Medical College, 1925; age 82, died March 7, 1980. Dr. Novicki, a family practitioner, was on the staff of St. Mary's Hospital.

• **Northern L. Powers, Jr.,** Pasadena, Texas; Jefferson Medical College, 1949; age 55, died March 27, 1980.

• **Samuel Zira Rose,** Philadelphia; Hahnemann Medical College, 1939; age 65, died April 8, 1980. Dr. Rose, a general practitioner, maintained offices in North Philadelphia and formerly was associated with St. Luke's Hospital.

• **Isaac R. Smith,** Nanticoke; Jefferson Medical College, 1929; age 75, died April 7, 1980. Dr. Smith was chief of medicine at Nanticoke Hospital and physician for Nanticoke's public schools.

• **George Aubrey Sowell,** Greencastle; Temple University School of Medicine, 1915; age 87, died May 4, 1980. Dr. Sowell had a general practice in Greencastle and was a member of the surgical staff at Waynesboro Hospital for more than 40 years.

**Carter N. Davison,** Tamaqua; Jefferson Medical College, 1958; age 52, died May 4, 1980.

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**For further information contact: Sharon Hanley, Geisinger Medical Center, Danville, PA 17821; (717) 275-6925.**

**DESCRIPTION:** Methyltestosterone is 17$\beta$-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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**Physician** — Large geriatric facility is seeking a full time Pennsylvania licensed physician. Job available April 1, 1981. Forty-hour work week. Liberal salary. Very attractive maintenance free home included. Full range of benefits plus fully paid malpractice insurance. Send resume to: Walter L. Wentzel, Jr., Executive Director, Masonic Homes, Elizabethtown, PA 17022.

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**Emergency medicine opportunities available** — Opportunities available to assume clinical and directorship responsibilities in several emergency departments located in western Pennsylvania. Excellent income, flexible scheduling, and paid professional liability insurance. Part-time opportunities also available. For details, send credentials in confidence to Mr. James Thomas, 230 Park Avenue, Suite 303, New York, New York 10169, or call collect (212) 599-0060.

**Emergency physician** — to join congenial six man group. Northwestern Pennsylvania 600 bed general hospital; 50,000 annual ED visits. Training in either Emergency Medicine or Surgery. Leadership or administrative experience desirable. Clean metropolitan community of 265,000; five area colleges; many cultural and recreational opportunities; year round outdoor activities. Join professional corporation after one year; 80K; fringes. Send C.V. to Department 840, Pennsylvania Medicine, 20 Erford Road, Lemoyne, PA 17043.

**Career opportunities** — Throughout Pennsylvania and from coast-to-coast for physicians in all specialties. All Fees assumed by employers. Send CV with objectives to Medical Recruitment Division, Dr. Personnel of Pittsburgh, Inc., (31 offices nationwide), 121 University Place, Pittsburgh, PA 15213, (412) 621-9975.

**Obstetrician-Gynecologist** — Indiana, Pennsylvania — A beautiful university community located 60 miles north and east of Pittsburgh, PA. Indiana Hospital is a 200-bed general hospital, completing a $22 million building and renovation program, which will provide the finest in medical facilities and equipment. It is the only general hospital in Indiana County, serving a population of over 80,000. The potential for a medical practice in obstetrics and gynecology is excellent due to a strong expanding economy and a young family growth in this area which has generated the need for additional physicians in this specialty. The area has an excellent school system, fine recreational facilities with lakes, streams, and mountain terrain for the various sports. The practice opportunity is open either for a private practice or in a partnership. Inquiries should be directed to either Richard N. Freda, MD, The Ben Franklin Medical Center, Shelley Dr., Indiana, PA 15701 (412) 463-0225 or Donald F. Smith, President, Indiana Hospital, Indiana, PA 15701 (412) 357-7120.

**House Staff Physician** — Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $40,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Executive Director, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

**Pediatrician and other physicians wanted** — for Bethel Park, Pennsylvania, suburb of Pittsburgh, 35,000 people. New professional building. Call (412) 833-6188.

## POSITIONS WANTED

**Thirty-two year old board certified internist** — University trained, extensive clinical experience, holding medical school appointment, seeks private practice opportunity in Philadelphia area, Northeast, or Midwest. Write Department 844, Pennsylvania Medicine, 20 Erford Road, Lemoyne, PA 17043.

## FOR SALE

**Office equipment** — including dictaphone, examination table, treatment stands, autoclave, etc. Call (717) 264-2815 or (717) 263-1996 after July 30, 1980.

**Ten room house** — and seven room adjoining office in community ten miles east of Hershey. Practice for price of home. Ideal for dermatologist, allergist, or general practitioner. Contact Nelson S. Scharadin, MD, 102 East Penn Avenue, Cleona, PA 17042; (717) 272-0302.

## CONTINUING EDUCATION

**Postgraduate Course in Bronchoesophagology** — Temple University, Chevalier Jackson Clinic, November 17th to 21st, 1980. Drs. Charles M. Norris, Gabriel F. Tucker, Jr., John A. Tucker, Bernard R. Marsh, and Myles G. Turtz. For further information write to: Chevalier Jackson Clinic, Temple University Hospital, 3401 North Broad Street, Philadelphia, PA 19140.

# OFFICIAL CALL TO THE 1980 HOUSE OF DELEGATES

The first installment of the Official Call was published in the June issue of PENNSYLVANIA MEDICINE. The purpose of the installments, as explained last month, is to accommodate the volume of material being presented by the Committee on Constitution and Bylaws which is a revision of the current Constitution and Bylaws of the Pennsylvania Medical Society.

The first installment covered new Chapters I through VIII and the accompanying Summary. Please refer to the Table of Contents for the proposed revision. This installment presents Chapters IX through XV and the accompanying Summary. The August issue of PENNSYLVANIA MEDICINE will present Chapters XVI through XXII and the accompanying Summary, which will complete Subject One, Proposed Amendments to the Constitution and Bylaws, of the Official Call. The August issue also will contain the balance of the customary Official Call items.

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The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Fairmont Hotel, Philadelphia, Pennsylvania, on Friday, October 31, 1980. The second session will convene Saturday, November 1, 1980 and the third session Sunday, November 2, 1980. Details regarding the starting times of all three sessions will appear in the Official Call in the August 1980 issue of PENNSYLVANIA MEDICINE.

## SUBJECT ONE: Proposed revision to amend the Constitution and Bylaws in their entirety

### Pennsylvania Medical Society Bylaws

### CHAPTER IX
### HOUSE OF DELEGATES

**Section 1 — Designation** — The House of Delegates shall be the legislative and policymaking body of this Society and shall conduct such business as is described in these bylaws.

**Section 2 — Duties** — In addition to the business to be conducted as prescribed in these bylaws, it shall be the duty of the House of Delegates to:

a. fill elective offices

b. elect representatives to the House of Delegates of the American Medical Association

c. fix the annual assessment

d. fix any special assessment

e. receive for consideration annual reports, official reports, resolutions, and other items of business

f. take such steps as may be necessary to further the purposes of this Society as stated in the Articles of Incorporation.

**Section 3 — Composition and Apportionment** — The House of Delegates shall be composed of voting delegates and ex-officio persons.

a. *Voting delegates shall be:*

1. Delegates elected by the component societies in the proportion of one delegate for every one hundred or fraction thereof its active or associate members whose assessments are paid or excused as of December 31 of the preceding year. In January of each year the Executive Vice President shall

### Source and Analysis

### CHAPTER IX
### HOUSE OF DELEGATES

**Section 1 — Designation** — Chapter III, Sections 1-11, pages 15-17 of the current Bylaws describes various aspects of the House of Delegates. This new section restates the general scope of authority of the House of Delegates from Article VI, Section 1 of the current Constitution.

**Section 2 — Duties** — Chapter III, Section 1, page 15 of the current Bylaws provides for additional duties of the House of Delegates such as filling elective offices, electing representatives to the AMA House of Delegates, and taking such steps as necessary to further the purposes of this Society. These duties have been included in this new section with some additional duties. Chapter IX, Section 1, page 22 of the current Bylaws alludes to authority of the House of Delegates to fix annual and special assessments. Article XI, Section 1, page 11 (last sentence) of the current Constitution clearly authorizes the House to fix the annual assessment. Therefore fixing annual and special assessments have been added to this new section dealing with duties of the House.

In addition, Chapter III, Section 8, page 16 of the current Bylaws specifically cites the duty of the House to consider reports and resolutions in order to transact business, and since this activity is the essence of a House of Delegates meeting, the duty to do so is added in this new section.

**Section 3 — Composition and Apportionment** — Article VI, Section 2, page 4 of the current Constitution describes who may be represented in the House of Delegates. This new section retains those provisions, adds "apportionment" to the heading for clarity, separates the voting delegates from the ex-officio members (nonvoting) of the House of Delegates, and describes alternates.

certify to each component society the number of delegates to which it is entitled during the current year.

2. The secretary from each component society in office at the time of any meeting of the House of Delegates.

3. A delegate from each specialty organized in Pennsylvania which is an American Medical Association Board certified specialty; such delegate must be an active or associate member in good standing of this Society.

4. A delegate from each of the active chapters of the American Medical Students Association in a medical school in the Commonwealth of Pennsylvania who is the president of said chapter.

5. A delegate from each special section of this Society organized under these bylaws;

b. *Ex-officio without the right to vote in the House of Delegates shall be:*

1. The president of each component society, if not an elected voting delegate from the component society.

2. The Speaker, Vice Speaker, and Immediate Past Speaker, except that when either the Speaker or Vice Speaker is presiding, the presiding person may vote only to break a tie vote on a business matter in the House of Delegates.

3. The President, the Immediate Past President, the President Elect, the Vice President, the Secretary, the Trustees, and the members of the Judicial Council, and other past presidents of this Society.

c. *Alternate Delegates* — Component societies are entitled to elect two alternate delegates for each delegate. Alternates may be seated as determined by the chairman of the delegation of each component society, or in the absence of a chairman, the secretary of the county society, or in the absence of either person, by the Credentials Committee. A delegation chairman may not unseat a delegate involuntarily.

Each specialty shall be entitled to elect one alternate who shall be an active or associate member in good standing of this Society.

A delegate who is a special student member may designate an alternate who also must be an active member in the same chapter of the American Medical Students Association.

Each delegate from a special section may designate an alternate who also is a member of that section.

**Section 4 — Terms of Delegates** — The terms of all delegates and alternates shall correspond to the calendar year.

**Section 4 — Terms of Delegates** — Article VI, Section 2, page 4 of the current Constitution provides for delegates terms to be "a year or for a term in excess of one year if such component society's bylaws provide for a longer term. . . provided that one delegate or alternate be elected. . . each year. . ." This requirement has been eliminated since component societies may make their own determinations. This new section stipulates that the terms of delegates and alternates must coincide with the calendar year.

**Section 5— Certification of Delegates and Members of the House** — The component medical societies, the specialty societies, and the special sections shall certify to the Executive Vice President of this Society the names of their respective delegates and alternates.

**Section 5 — Certification of Delegates and Members of the House** — Chapter III, Section 4 of the current Bylaws is a lengthy and wordy explanation of certification or credentialing delegates and seating of delegates. This new section uses simpler language and shorter sentences and

The Secretary of this Society shall certify to the Credentials Committee the names of the special student members who are delegates and alternates.

Prior to the opening of a House of Delegates meeting, the Executive Vice President shall certify to the Credentials Committee the names of all delegates, alternates, and ex-officio members of the House of Delegates.

Such certification shall be sufficient for the seating of the secretaries or presidents of component societies and for identification of the voting and nonvoting members of the House of Delegates.

retains the certification requirements. The seating of delegates becomes Section 7 in the revised version.

This Society mails forms to all components and others who attend meetings of the House of Delegates. The returns are compiled administratively and the list is used at the registration desk on behalf of the Credentials Committee for identifying those registering.

**Section 6 — Registration of all Members and Other Persons in the House of Delegates** — All delegates and alternates must register in person with the Credentials Committee. All ex-officio and nonvoting members of the House of Delegates shall likewise register in person. All other persons, whether members of this Society or of some other organization, who wish to take part in the activities of the House of Delegates shall likewise register.

**Section 6 — Registration of All Members and Other Persons in the House of Delegates** — Chapter III, Section 4, page 16 of the current Bylaws alludes to registering "in person" at a meeting of the House. This new section specifically cites the requirement to register in person and applies it to all persons taking part in the activities of the House.

Although open sessions of House meetings are open to the public, this suggests that nonmembers and administrative staff should notify the registration desk of their attendance.

**Section 7 — Seating of Delegates** — Once properly registered, delegates or alternates, as the case may be, may be seated. Seated delegates remain such until the final adjournment of the meeting unless substituted for by an alternate in accordance with procedures outlined in these bylaws.

a. *Components Unrepresented* — If any component society is not represented by a delegate or alternate at any session of the meeting, then an active or associate member of the Society registered and in attendance may be seated as the delegate after receiving approval of the Credentials Committee.

b. *Waiving Certification Requirements* — The certification requirements for the seating of a delegate may be waived by the Credentials Committee in unusual cases.

c. *Seating Disputes* — Any dispute arising as to the seating of any delegate or alternate shall be referred to the Credentials Committee which shall report its finding to the House of Delegates which shall make the final determination.

**Section 7 — Seating of Delegates** — Chapter III, Section 4, pages 15-16 of the current Bylaws includes credentialing, certification, and seating of delegates. This new section discusses the seating of delegates separately and follows Section 6 which outlines the requirements for certification and registration.

a. *Components Unrepresented* — Article VI, Section 3 of the current Constitution includes a paragraph explaining how a component society unrepresented by a delegate or alternate may be represented by a member in attendance from that component. This new section provides the same remedy for those components unrepresented by a delegate or alternate.

b. *Waiving Certification Requirements* — Chapter III, Section 4, pages 15-16 of the current Bylaws also provides for waiving of certification requirements and the resolving of seating disputes. This new section contains those same provisions slightly reworded.

c. *Seating Disputes* — See above.

**Section 8 — Vote** — Each seated delegate is entitled to one vote and is prohibited from casting another delegate's vote.

**Section 8 — Vote** — Article VI, Section 4, page 5 of the current Constitution entitles a seated delegate to one vote and prohibits such delegate from voting for any other delegate. This new section contains the same provision slightly reworded.

**Section 9 — Quorum** — Seventy-five seated delegates shall constitute a quorum to conduct business of any session of a meeting of the House of Delegates.

**Section 9 — Quorum** — Chapter III, Section 5, page 16 of the current Bylaws stipulates the necessary quorum. This new section increases the number to seventy-five to accommodate the growing number of delegates in the House.

**Section 10 — Official Reports Book** — The official busi-

**Section 10 — Official Reports Book** — There is no mention

ness of the House of Delegates shall be contained in the Official Reports Book. The Official Reports Book may contain other such material as is incidental to a meeting of the House of Delegates. The Executive Vice President shall have responsibility for the preparation of the Official Reports Book.

The introduction of reports and resolutions shall be governed by the Standing Rules of the House of Delegates.

in the current Bylaws of the Official Reports Book. This new section provides that there be a handbook for meetings of the House of Delegates and that the particulars regarding the introduction of official business shall be governed by Standing Rules of the House. It also establishes that the executive vice president is responsible for its preparation.

**Section 11 — Rules of Order** — *Sturgis Standard Code of Parliamentary Procedure* shall be the official reference governing the meetings of the House of Delegates.

**Section 11 — Rules of Order** — Chapter III, Section 6, page 16 of the current Bylaws cites the Parliamentary guide for the meeting of the House. This new section contains the same provision slightly reworded.

**Section 12 — Open, Closed, and Executive Sessions** — The House of Delegates shall meet in open session to which any person who has registered as prescribed by the bylaws may attend.

The House of Delegates may move into closed session. A closed session is restricted to seated delegates of the House of Delegates, members of this Society who have registered in accordance with these Bylaws, legal counsel of this Society, and the administrative staff of this Society and component societies.

The House of Delegates may move into executive session. An executive session is restricted to registered members of the House of Delegates, legal counsel of this Society, and necessary administrative staff of this Society.

**Section 12 — Open, Closed, and Executive Sessions** — Chapter III, Section 10, page 17 of the current Bylaws provides for the different sessions and who is permitted to attend.

This new section restates those provisions with the additional provision that persons shall register before attending.

**Section 13 — Official Proceedings** — The official proceedings of an annual or special meeting of the House of Delegates shall be published in the official journal of this Society in a timely fashion or disseminated to the membership by some other means at the discretion of the Secretary.

Proceedings of closed and executive sessions shall not be published.

**Section 13 — Official Proceedings** — Chapter III, Section 11, page 17 of the current Bylaws requires the publication of the proceedings of an annual or special meeting of the House in the first possible journal following the meeting. This section also states that proceedings of closed or executive sessions of a meeting shall not be published.

This new section provides for the proceedings to be disseminated to the membership via publication in the journal or by some other means at the discretion of the Secretary. This new section allows flexibility to disseminate proceedings sooner and at less cost if possible.

## CHAPTER X
## COMMITTEES OF THE HOUSE OF DELEGATES

## CHAPTER X
## COMMITTEES OF THE HOUSE OF DELEGATES

**Section 1 — Designation** — There shall be meeting committees necessary to the operation of the annual meeting of the House of Delegates and such reference committees as deemed necessary by the Speaker.

**Section 1 — Designation** — Chapter III, Section 3, page 15, of the current Bylaws provides for a Credentials Committee. Chapter III, Section 7, page 16 of the current Bylaws provides for a Committee on Rules. Chapter III, Section 9, page 17 of the current Bylaws provides for Reference Committees. This new section distinguishes meeting committees, such as Credentials and Rules, from Reference Committees.

**Section 2 — Meeting Committees** — Meeting committees shall consist of the Credentials Committee and the Rules Committee.

a. *Credentials Committee* — This committee shall be appointed by the Speaker and consist of five delegates, who shall serve in this capacity for the duration of the annual or special meeting for which they are appointed.

**Section 2 — Meeting Committees**

a. *Credentials Committee* — Chapter III, Section 3, page 15 of the current Bylaws provides that a Credentials Committee be appointed to serve until May 31 following a meeting of the House of Delegates. Its duties are described in this section and in Chapter III, Section 4, page 16 of the current Bylaws.

This new section retains the same appointment re-

This committee shall be responsible for consideration of all matters relating to the certification and registration of delegates and alternates; may waive certification requirements in unusual cases; and shall report to the House of Delegates for final determination any unresolved dispute regarding the seating of a delegate.

This committee also shall report to the House of Delegates at each session of a meeting the number of delegates in attendance and the existence of a quorum.

b. *Rules Committee* — This committee shall be appointed by the Speaker and consist of five delegates who shall serve in this capacity from the time they are appointed until the adjournment of the meeting for which they are appointed.

This committee shall be responsible for proposing necessary or desirable rules of procedure for the orderly transaction of business at an annual or special meeting of the House of Delegates; the order of business for a special meeting must include any matter set forth in the official call to that meeting.

*These rules of procedure shall be designated the Standing Rules.*

1. The "Order of Business" for the meeting which shall be adopted as the first order of business by a majority vote of the seated delegates.
2. Standing Rules, which remain in effect unless altered or rescinded by the House of Delegates, may be changed at any session of the meeting by a two-thirds vote of the seated delegates.
3. Standing Rules may not conflict with these bylaws.

quirement and the duties in simpler language. In addition, this new section requires that the Credentials Committee serve only for the duration of the meeting of the House. There is no work for this Committee once the House has adjourned. This new section adds the duty that the Credentials Committee reports to each session of a meeting of the House and repeats the provision from Chapter III, Section 4, page 16 of the current Bylaws that the House makes final determination in seating disputes.

b. *Rules Committee* — Chapter III, Section 7, page 16 of the current Bylaws provides for a Rules Committee to be appointed to serve until May 31 following a meeting of the House and details the duties of the Rules Committee.

This new section repeats the appointment and duties of the Rules Committee in slightly different language, and changes the length of service from the time of appointment to the adjournment of the meeting for which they have been appointed. This also cites the existence of Standing Rules, their adoption, content, amendments, and the requirement that they not conflict with these bylaws.

**Section 3 — Reference Committees** — The Speaker of the House of Delegates shall appoint such number of reference committees as the Speaker deems necessary and clearly identify them. On each committee there shall be five members and such alternates as the Speaker deems necessary. The Speaker shall designate the chairmen. These committees shall serve for the duration of the meeting for which they are appointed with the exception of the reference committee designated to consider bylaws amendments.

The Standing Committee on Bylaws, also appointed by the Speaker, shall serve as that reference committee which considers bylaws amendments.

a. *Duties* — Each reference committee shall receive all reports, resolutions, and other items of business referred to it by the Speaker.

Each reference committee shall hold an open hearing on all business referred to it at which any member of this Society has the right to appear and be heard.

In Executive Session, each committee shall discuss and evaluate the business and the opinions expressed by the members. Each committee then shall report its conclusions and recommendations to the House of Delegates at the call of the Speaker.

b. *Final Action* — The reports of the reference committees shall be presented to the House of Delegates before final action may be taken except when two-thirds of the seated delegates vote otherwise.

The House of Delegates shall determine final action on all matters reported by reference committees.

**Section 3 — Reference Committees** — Chapter III, Section 9, page 17 of the current Bylaws describes the composition and general responsibilities of reference committees. This new section retains all the provisions slightly reworded. For clarity, the material is divided into a) duties and b) final action.

## CHAPTER XI
## NOMINATIONS

**Section 1 — Origin of Nomination** — Nominations for all offices to be elected by the House of Delegates may be made by seated delegates from the floor of the House. To be accepted by the House, nominees should possess the prescribed qualifications for the office for which they are nominated.

Nominations for delegates and alternates to the American Medical Association shall be made by the Committee to Nominate Delegates and Alternates to the American Medical Association.

Nominations for the Judicial Council shall be made by the Board of Trustees at least 30 days prior to an annual meeting. At least three qualified persons shall be nominated for each expiring term. These names should be disseminated to the members of this Society via the official journal of this Society or by some other appropriate means determined by the Secretary.

Nominations for Trustees shall be made from the floor of the House and only by seated delegates from their respective districts for which positions need to be filled.

## CHAPTER XI
## NOMINATIONS

**Section 1 — Origin of Nominations** — Chapter IV, Section 4, page 18 of the current Bylaws describes who may nominate persons for various offices, the district censors, Trustees positions, AMA Delegation positions, and Judicial Council positions.

This new chapter retains the same stipulations except where district censors are concerned. District censors should not be considered *officers* of this Society, but part of the disciplinary/judicial branch.

According to Article V, Separation of Powers, page 3 of the current Constitution, members of disciplinary bodies may not serve as officers. Article X, Officers, page 9 of the current Constitution lists District Censors as general officers. This is improper and inconsistent since these persons do not function in administrative capacities but rather in disciplinary proceedings. The conflict between the aforementioned Articles V and X generates another impropriety. Many component societies have delegates serving as district censors. This conflicts with Article V, Separation of Power, page 3 of the current Constitution, which prohibits officers from being delegates.

Please note that District Censors are not included in Chapter XIII, Officers, in this revision, but are described in Chapter XIX, of this revision in conjunction with Disciplinary Bodies, Proceedings, and Appeals.

## CHAPTER XII
## ELECTIONS

**Section 1 — Holding Elections** — Elections shall be held in accordance with these bylaws and the Standing Rules of the House of Delegates.

**Section 2 — Election by Ballot** — All contested elections shall be by ballot and a majority vote shall be necessary to elect candidates except that delegates and alternates to the American Medical Association shall be elected by a plurality vote.

**Section 3 — Election by Acclamation** — Election by acclamation shall be valid when there is no contest and therefore such positions need not be included on a ballot.

**Section 4 — Tellers** — The Speaker shall appoint such number of tellers who shall be responsible to the Speaker for a count on a vote in any session of the meeting of the House of Delegates. Tellers are also responsible for the counting of all ballots and reporting the results directly to the Speaker.

## CHAPTER XII
## ELECTIONS

**Section 1 — Holding Elections** — Article VI, Section 1, page 4 of the current Constitution charges the House of Delegates with filling elective offices. Therefore, as previously explained, this duty is listed in Chapter IX, Section 2 of this revision. Chapter IV, Elections, page 17 of the current Bylaws does not make reference to the holding of elections per se.

This revised chapter incorporates the requirement for holding elections which appears in Article VI, Section 1, page 4 of the current Constitution, slightly reworded.

**Section 2 — Election by Ballot** — Chapter IV, Section 1, page 17 of the current Bylaws stipulates all elections be by ballot, with the exception of delegates and alternates to the AMA. This new section repeats these stipulations slightly reworded.

**Section 3 — Election by Acclamation** — The current Bylaws does not address elections by acclamation. This in fact occurs at annual meetings when there is no contest for a position. This new section provides for election by acclamation.

**Section 4 — Tellers** — Chapter IV, Section 2, page 17 of the current Bylaws authorizes the speaker to appoint such tellers as he deems necessary. This new section retains the appointment authority of the speaker and specifies the tellers' duties to count votes in the House if called upon to do so and to count all election ballots and report to the speaker.

The time of elections, which is the main subject of Chapter IV, Section 2, page 17 of the current Bylaws is not referred to specifically in the revision but is generally provided for in Chapter X, Section 2b of this revision.

**Section 5 — Commencement of Terms** — The terms of all elected officers, and members of the Board of Trustees and the Judicial Council commence at the conclusion of the annual meeting at which they are elected.

Delegates and Alternates to the American Medical Association assume their duties in accordance with the bylaws of that organization.

**Section 5 — Commencement of Terms** — Chapter IV, Section 3, page 17 of the current Bylaws stipulates in general when terms commence for those persons elected at the meeting of the House. This new section repeats that stipulation with specific references to those elected.

**Section 6 — Duration of Terms** — The terms for elected positions shall be as prescribed in these bylaws.

**Section 6 — Duration of Terms** — There is no general reference to the duration of the aforementioned terms in the current Constitution or Bylaws. This new section provides for the duration of the term to be prescribed according to the bylaws since not all terms are the same.

## CHAPTER XIII
## OFFICERS

## CHAPTER XIII
## OFFICERS

**Section 1 — Designation** — The officers of this Society shall be a president, a president elect, a vice president, an immediate past president, a secretary, a treasurer, a speaker, and a vice speaker of the House of Delegates. There may be such assistant treasurers and assistant secretaries as may be designated by resolution by the Board of Trustees.

**Section 1 — Designation** — Article X, Section 1, page 9 of the current Constitution describes what officers the Society shall have and includes district censors. This new section provides for the same designation excluding district censors. As previously explained, district censors do not function as officers but rather in a disciplinary capacity when needed. Please refer to Chapter XI, Section1, Origin of Nomination and Chapter XIX, Disciplinary Bodies, Proceedings, and Appeals of this revision and their corresponding summaries.

**Section 2 — Qualifications** — All officers of this Society must be active or associate members of this Society elected according to these bylaws except that the treasurer may be a corporation or an employee of the Society appointed by the Board of Trustees. In the event that the treasurer is an individual, the Board of Trustees may combine this office with that of the executive vice president.

The assistant treasurers and assistant secretaries may be employees of the Society. The speaker and vice speaker must be members of the House of Delegates at the time of their election.

**Section 2 — Qualifications** — Article X, Section 2, page 9 of the current Constitution describes the basic membership qualifications for officers of the Society. This new section repeats the requirement slightly reworded to accommodate the new reference to variations in membership categories from Chapter 1, Section 3 of this revision.

Chapter VI, Section 6, page 20 of the current Constitution gives the Board the authority to combine the treasurer's duties with that of the executive vice president's office and this provision is repeated in this new section.

**Section 3 — Terms of Office** — The period of time between the conclusion of one annual meeting of the House of Delegates and the conclusion of the next annual meeting shall be considered the term of office.

a. The *vice president* serves from the conclusion of the annual meeting at which he was elected until the next annual meeting at which time he accedes to the office of president elect.

b. The *president elect* serves from the conclusion of the annual meeting at which he acceded to this office and serves until the next annual meeting at which time he accedes to the office of president.

c. The *president* shall serve from the conclusion of the annual meeting until the conclusion of the next annual

**Section 3 — Terms of Office** — Chapter IV, Section 3, page 17 of the current Bylaws mandates that terms of office for those persons selected at an annual meeting commence at the conclusion of that meeting. This requirement is restated in Chapter XII, Section 5 of this revision.

Article X, page 9 of the current Constitution implies in Sections 3 and 4 that officers elected serve a term until the next annual meeting. This new section is explicit in designating the terms for officers and then describes individual offices instead of in groups such as the current Section 3 of Article X dealing with the vice president, president-elect, and president, and Section 4 of Article X dealing with other officers.

meeting, at which time he becomes the immediate past president.

d. The *immediate past president* shall serve from the time he becomes such until the conclusion of the next annual meeting.

e. A *secretary* shall serve from the conclusion of the annual meeting of the House of Delegates at which elected until the next annual meeting at which a successor is elected.

f. A *speaker* and a *vice speaker* shall serve from the conclusion of the annual meeting of the House of Delegates at which elected until the next annual meeting at which successors are elected.

g. The *treasurer* shall serve from the Reorganizational Meeting of the Board of Trustees of the annual meeting at which appointed by the Board of Trustees until the next Reorganizational Meeting.

**Section 4 — Officers Acceding Automatically** — In the event that circumstances beyond the control of the Society prevent the holding of the annual meeting of the House of Delegates, the vice president shall automatically accede to the office of president elect and the president elect shall automatically accede to the office of president at the previously announced time for the annual meeting.

Other offices shall be filled according to the bylaws.

**Section 4 — Officers Acceding Automatically** — Article X, Section 3, page 9 of the current Constitution also includes a paragraph on officers acceding to the next position if the House of Delegates is prevented from an annual meeting. This new section repeats the clause slightly reworded.

**Section 5 — Successor in Case of Vacancies to the President, President Elect, and Vice President** — If the office of president should become vacant, the president elect shall immediately become president and shall serve as president until the second annual meeting of the House of Delegates following his accession as president elect.

If the office of president elect becomes vacant, the vice president shall immediately become president elect and shall serve for the remainder of the term of his immediate predecessor.

If the office of vice president becomes vacant, such shall remain vacant until the next annual meeting of the House of Delegates at which time the House of Delegates shall elect an eligible person as president elect and an eligible person as vice president.

If the offices of both president and president elect become vacant, the vice president shall immediately become president and shall serve as president until the second annual meeting of this Society following his election as vice president.

If the offices of both president elect and vice president become vacant, the Board of Trustees shall designate from the Board of Trustees one who shall act as president elect and one who shall act as vice president, each of whom shall so act until the next annual meeting of the House of Delegates, at which time the House of Delegates shall elect an eligible person as president and an eligible person as vice president.

If the offices of president, president elect, and vice president should become vacant, the Board of Trustees shall designate from among the Board of Trustees one who shall act as president, one who shall act as president elect, and one who shall act as vice president, each of whom shall so act until the next annual meeting of the House of Dele-

**Section 5 — Successors in Case of Vacancies to the President, President-Elect, and Vice President** — Article X, Section 5, page 9 of the current Constitution describes what transpires if vacancies occur in these aforementioned offices. This new section repeats and preserves those provisions, slightly reworded.

gates, at which time the House of Delegates shall elect an eligible person as president, an eligible person as president elect, and an eligible person as vice president.

Should the president be incapacitated or unable to perform the duties of this office, as determined by the Board of Trustees, the president elect shall act in his stead. Should the president elect be incapacitated or unable to perform the duties of his office, as determined by the Board of Trustees, the vice president shall act in his stead. Should both the president and the president elect be incapacitated or unable to perform the duties of their offices, as determined by the Board of Trustees, the vice president shall act in their steads.

**Section 6 — Vacancies in Other Offices** — Vacancies in any office, other than that of the speaker of the House of Delegates, occurring between annual meetings of the House of Delegates shall be filled by the Board of Trustees and such persons shall serve until the next annual meeting at which their successors are elected.

The vice speaker shall act for the speaker in the event of a vacancy in that office or the speaker's inability to act.

**Section 6 — Vacancies in Other Offices** — Article X, Section 6, page 10 of the current Constitution gives authority to the Board of Trustees to fill vacant offices other than those mentioned in the aforementioned Section 5. The details are repeated in this new section.

**Section 7 — Duties of Officers** — In addition to duties prescribed in these bylaws, officers shall have such duties as may be normally incident to their respective offices or as may be directed by the Board of Trustees.

a. *The president shall:*

1. be an ex-officio member of the Board of Trustees with the right to vote and be an ex-officio member of the House of Delegates without the right to vote;
2. be an ex-officio member of all committees and administrative councils and commissions without the right to vote;
3. fill vacancies on administrative councils, commissions, or standing committees according to these bylaws;
4. delegate duties to the president-elect, vice president, and the immediate past president;
5. file a report on the term as president with the House of Delegates at its annual meeting; and
6. address the House of Delegates at its annual meeting during the opening session.

b. *The president elect shall:*

1. be an ex-officio member of the Board of Trustees with the right to vote;
2. be an ex-officio member of the House of Delegates without the right to vote;
3. perform such duties as are delegated by the president; and
4. make appointments to committees and administrative councils and commissions as prescribed in these bylaws.

c. *The vice president shall:*

1. be an ex-officio member of the Board of Trustees with the right to vote;
2. be an ex-officio member of the House of Delegates without the right to vote;
3. perform such duties as are delegated by the president and president elect.

d. *The immediate past president shall:*

1. be an ex-officio member of the Board of Trustees with the right to vote;

**Section 7 — Duties of Officers** — Article X, Section 7, page 10 of the current Constitution describes the general scope of the duties of officers. This new section repeats and preserves those general provisions.

a. Chapter VI, Section 1, page 19 of the current Bylaws describes more specific duties of the president which are slightly reworded and presented in a different format in this new section as item a.

b. Chapter VI, Section 2, page 19 of the current Bylaws describes more specific duties of the president-elect which are slightly reworded and presented in a different format in this new section as item b.

c. Chapter VI, Section 3, page 20 of the current Bylaws describes general duties of the vice president which are slightly reworded and presented in a different format in this new section as item c.

d. There is no reference to the office of the immediate past president in the current Bylaws and no reference to any duties of the office except that Article VI, Section 2,

2. be an ex-officio member of the House of Delegates without the right to vote; and

3. perform such duties as may be delegated by the president.

page 4 of the current Constitution provides for the immediate past president to be ex-officio without the right to vote in the House of Delegates and Article VIII, Section 2, page 6 of the current Constitution provides for the immediate past president to be ex-officio on the Board of Trustees. This new section combines those provisions and adds the duty to perform such duties as may be delegated by the president. This appears as item d in this new section, thereby giving the office of the immediate past president clear definition.

e. *The secretary shall:*

1. be an ex-officio member of the House of Delegates without the right to vote;

2. be responsible for the minutes of all Board of Trustees' meetings and the minute books;

3. be responsible for the official proceedings of all House of Delegates meetings;

4. file an annual report with the House of Delegates;

5. report to the Board of Trustees as necessary;

6. serve as secretary to the Judicial Council and in concert with that duty may give advice as to previous rulings of the Judicial Councils of the AMA and/or this Society, but shall not in so doing invade the exclusive jurisdiction of those Judicial Councils to interpret the Principles of Medical Ethics, and in this regard may give advice as to previous rulings of courts;

7. serve as a member of the Committee on Medical Benevolence and as its secretary;

8. serve as chairman of the Advisory Committee on Professionalism; and

9. perform such duties described in these bylaws with respect to matters regarding medical ethics or discipline.

e. Article X, Section 1, page 9 of the current Constitution designates a secretary to be an officer of this Society. Article VI, Section 2, page 4 of the current Constitution designates the secretary as ex-officio without the right to vote in the House of Delegates. Article VIII, Section 2 of the current Constitution describes the officers who serve on the Board of Trustees in which the secretary is not mentioned. Article IX, Section 5, page 8 of the current Constitution describes the secretary's duty with respect to the Judicial Council. Article VII, Sections 1 and 2, pages 5 and 6 of the current Constitution describe the secretary's responsibility with respect to the official calls to meetings of the House of Delegates.

Chapter VI, Section 5, page 20 of the current Bylaws provides that the secretary perform other duties regarding minutes of Board meetings, of this Society and the House of Delegates, reporting to the Board and the House, medical ethics and disciplinary proceedings. Chapter VI, Section 9, page 21 of the current Bylaws provides for the secretary to affix the seal of this Society as required. Chapter XIV, Section 2c, page 31 of the current Bylaws designates the secretary to serve on the Committee on Medical Benevolence and Section 2f of the same chapter, page 30 of the current Bylaws provides for the secretary to serve as Chairman of the Advisory Committee on Professionalism.

All these duties are included in this new section as item e.

f. *The assistant secretaries:*

1. shall perform such duties as determined by the Board of Trustees;

2. may exercise the powers and duties of the secretary at the direction of the chairman of the Board of Trustees until the next meeting of the Board in the event the secretary is unable to act during the interim.

f. Chapter VI, Section 8, page 21 of the current Bylaws describes general duties of assistant secretaries. This new section repeats those duties slightly reworded as item f.

g. *The treasurer:*

1. shall have custody of all funds and securities of this Society;

2. shall deposit all monies and securities as is appropriate at the direction of the Board of Trustees;

3. shall sell and purchase securities as directed by the Board of Trustees;

4. shall disburse the funds of this Society within budgetary limitations and as directed by the Board of Trustees, except as otherwise provided in these bylaws;

5. may delegate limited authority to the executive vice president, an assistant treasurer, or a bonded staff member to disburse money for necessary and usual operating expenses of this Society;

6. shall report at regular meetings of the Board of Trustees;

g. Chapter VI, Section 6, page 20 of the current Bylaws describes more specific duties of the treasurer of this Society which are slightly reworded and presented in a different format in this new section as item g. The provision that if the treasurer is an individual the Board of Trustees may combine this office with that of the executive vice president has been included in Chapter XII, Section 2 of this revision.

7. shall report to the annual meeting of the House of Delegates.

h. *The assistant treasurer:*

1. shall perform such duties and exercise such powers as determined by the Board of Trustees; and

2. may exercise all the power and duties of the treasurer as directed by the chairman of the Board of Trustees until the next Board of Trustees meeting if the treasurer is unable to act.

h. Chapter VI, Section 7, page 20 of the current Bylaws describes general duties of assistant treasurers. This new section repeats those duties slightly reworded as item h.

i. *The speaker of the House of Delegates:*

1. shall preside at all meetings of the House of Delegates or designate the vice speaker to do so, and perform such other duties as may be required by these bylaws;

2. shall appoint the members of the Standing Committee on Bylaws and designate its chairman;

3. shall appoint committees of the House of Delegates and designate their chairmen;

4. shall determine the number of reference committees and appoint the members of each;

5. shall determine the appropriate referral of business items to each reference committee;

6. shall be ex-officio with the right to vote on the Board of Trustees;

7. shall be ex-officio without the right to vote in the House of Delegates;

8. may delegate a chairman to preside at a meeting of the House of Delegates.

i. Article VI, Section 2, page 4 of the current Constitution provides for the speaker and vice speaker to be ex-officio without the right to vote in the House of Delegates. Chapter VI, Section 4, page 20 of the current Bylaws describes the general authority of the speaker and vice speaker.

Chapter III, Section 3, page 15 and Section 7, page 16 of the current Bylaws provide for the appointment authority of the speaker for the Credentials Committee and the Rules Committee respectively.

Chapter III, Section 9, page 17 of the current Bylaws provides the appointment authority of the speaker for reference committees of the House of Delegates.

Chapter XIV, Section 2 of the current Bylaws provides the appointment authority of the speaker for the Standing Committee on Constitution and Bylaws. This section also gives the speaker the referral authority of business items.

All these duties have been listed as item i with the added duty that the speaker shall be ex-officio with the right to vote on the Board of Trustees. Article VIII, Section 2, page 6 of the current Constitution designates the speaker and vice speaker ex-officio without the right to vote. Please refer to Chapter XV, Section 3 of this revision which provides for the speaker and vice speaker to have a vote.

j. *Vice speaker of the House of Delegates:*

1. shall preside at all meetings of the House of Delegates in the absence of the speaker or as designated by the speaker;

2. shall perform such duties as delegated by the speaker in conjunction with meetings of the House of Delegates in the absence of the speaker;

3. may delegate a chairman to preside at a meeting of the House of Delegates.

j. The duties of the vice speaker from all the abovementioned sections have been listed separately as item j with the added duty to be ex-officio with the right to vote on the Board of Trustees. Please see note for speaker, item i.

**Section 8 — Execution of Documents** — The chairman of the Board of Trustees, the president, the president elect, the vice president, or the treasurer shall execute on behalf of this Society under its seal any bonds, deeds, mortgages, or other contracts approved by the Board of Trustees.

The secretary, assistant secretary, treasurer, or assistant treasurer shall affix the seal of this Society to any instrument requiring it, and when affixed it shall be attested by such officer's signature, provided, however, that the treasurer shall not attest to the seal affixed to any instrument which he has executed on behalf of this Society.

**Section 8 — Execution of Documents** — Chapter VI, Section 9, page 21 of the current Bylaws details who may execute certain transactions and who may affix the seal to instruments. These provisions are repeated unchanged in this new section.

## CHAPTER XIV
## THE EXECUTIVE VICE PRESIDENT

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## THE EXECUTIVE VICE PRESIDENT

**Section 1 — Designation** — There shall be an executive vice president who shall be the administrative head of the Society appointed by the Board of Trustees.

**Section 1 — Designation** — Chapter V, Section 1, page 18 of the current Bylaws charges the Board of Trustees with the duty to appoint an executive vice president. Chapter

VII, Section 1, page 21 of the current Bylaws includes the designation that the executive vice president is the administrative head of this Society. This new section combines these elements to clearly define the executive vice president position.

**Section 2 — Duties** — In addition to being responsible for the administration of the headquarters of this Society and other duties described elsewhere in these bylaws, within the budgetary limitations imposed by the Board of Trustees, the executive vice president shall:

a. employ such personnel at such salaries and under such terms and conditions of employment as he shall determine;

b. provide administrative assistance and arrange the business details and facilities for meetings of the House of Delegates, the Board of Trustees, the Judicial Council, the officers and the committees, administrative councils and commissions as he deems necessary for the efficient operation of this Society;

c. repair and maintain the real and personal property of this Society;

d. be responsible for the preparation of all agendas for meetings of the Board of Trustees and the House of Delegates, including the Official Reports Book, and shall be required to attend such meetings;

e. conduct the correspondence of this Society, notify all members of their election to office or their appointments to committees, administrative councils and commissions, and issue over the proper signature all notices required by these bylaws or the House of Delegates or the Board of Trustees;

f. be the custodian of and supervise and maintain at the office of this Society the membership records and roster and all other record books and papers of this Society;

g. be responsible for the publication of the journal under the supervision of the Publication Committee;

h. employ a managing editor who shall assist in the publication of the official journal of this Society;

i. be responsible for the publication of the annual roster, memoirs, and any other publications of this Society;

j. prepare a necrology report for presentation by the Board of Trustees at the annual meeting of the House of Delegates;

k. render a report to the Board of Trustees at each of its meetings;

l. render a report to the House of Delegates at its annual meeting; and

m. assume the duties of the Secretary if necessary and as directed by the Board of Trustees.

**Section 2 — Duties** — Chapter VII, Section 1, pages 21 and 22 of the current Bylaws details the duties of the executive vice president. This new section repeats those duties slightly reworded as a result of editing and in a different format for clarity.

**Section 3 — Limitations** — If a member of this Society, the executive vice president shall not, except as expressly permitted in these bylaws, be eligible to vote or hold any office in the Society, nor to serve as a member of any council, commission, or committee.

**Section 3 — Limitations** — Chapter VII, Section 1, page 22 of the current Bylaws includes a paragraph on the limitation on the executive vice president if a member of this Society. This provision is repeated in this new section slightly reworded.

**Section 4 — Vacancy** — In the event of a vacancy in the position of the executive vice president, the Board of Trustees or its executive committee shall designate a member of the administrative staff to act as executive vice president until a permanent appointment is made.

**Section 4 — Vacancy** — Chapter VII, Section 2, page 22 of the current Bylaws describes what happens if a vacancy occurs in the executive vice president's position. This new section repeats the provision slightly reworded as a result of editing.

## CHAPTER XV
## THE BOARD OF TRUSTEES

**Section 1 — Designation and General Authority** — There shall be a Board of Trustees which shall be the policymaking body of this Society between meetings of the House of Delegates, but which may not establish any policies that are inconsistent with prior policies established by the House of Delegates.

**Section 2 — Duties of the Board** — In addition to the general authority described in these bylaws, the Board shall:

a. have charge of the property and financial affairs of this Society including the authority to purchase, mortgage, lease, sell, or otherwise dispose of any real estate;

b. perform such other duties as are prescribed by law governing directors of corporations and in these bylaws;

c. borrow money on behalf of this Society;

d. invest funds on behalf of this Society;

e. require the treasurer, assistant treasurers, secretary, assistant secretaries, the executive vice president and all employees handling funds of this Society to furnish, at the cost to this Society, corporate surety bonds in such amounts determined by the Board of Trustees for the faithful discharge of their respective duties and for the return of all books, papers, and documents belonging to this Society;

f. appoint the executive vice president and fix his salary or other compensation and terms of employment;

g. appoint the medical editor of the journal and fix his salary or other compensation and terms of employment;

h. fix the salaries or other compensation and terms of employment of the secretary and the treasurer;

i. supervise the business and editorial affairs of the journal;

j. elect delegates and alternates to the House of Delegates of the American Medical Association to fill vacancies created by an apportionment occurring between meetings of the House of Delegates of this Society and for this purpose may request the Committee to Nominate Delegates and Alternates to the American Medical Association to submit the names of one or more nominees;

k. appoint substitute delegates and substitute alternates to the House of Delegates of the American Medical Association when permitted to do so by the Bylaws of the American Medical Association;

l. authorize the expenditure of monies of the Society to defray legal expenses associated with the defense of individual members, groups of members, or county societies in any case where it believes the best interests of a substantial number of members are so served;

m. exercise general supervision over the conduct of all administrative councils and committees between annual meetings of the House of Delegates;

n. fill any vacancies as prescribed by these bylaws;

o. report to the House of Delegates at the annual meeting;

p. review all resolutions and recommendations from the House of Delegates pertaining to the expediture of funds. The Board of Trustees must approve of such expenditures before the same shall become effective.

CHAPTER XV
THE BOARD OF TRUSTEES

**Section 1 — Designation and General Authority** — Article VIII, Section 1, page 6 of the current Constitution describes the general scope of the authority of the Board of Trustees. This new section designates that there shall be a Board of Trustees, and repeats the general scope of its authority.

**Section 2 — Duties of the Board** — Article VIII, Section 1, page 6 of the current Constitution and Chapter V, Section 1, page 18 of the current Bylaws contain specific duties of the Board of Trustees as a whole.

Chapter IX, Section 4, page 23 of the current Bylaws cites other duties which include the requirement that the Board must approve expenditures recommended by the House of Delegates before becoming effective and further, that the Board approve budgets for expenditures of funds of this Society, and in order to disburse money in special funds that the Board determine such by general or specific resolutions.

Chapter IX, Section 5, page 23 of the current Bylaws directs the Board to have audited all accounts of this Society, and provide an annual report of such audit to the House of Delegates at its annual meeting.

Article IV, Section 6, page 2 of the current Constitution provides that the Board approve affiliate member applications before becoming effective.

Chapter IX, Section 6, page 23 of the current Constitution provides for the Board to appropriate a percent of the annual assessments of active members to contribute to the Medical Benevolence Fund and in addition, that the Board may impose a limitation on the amount of money paid out of the Fund to recipients.

Chapter IX, Section 7, page 24 of the current Constitution requires the Board to appropriate a percent of the annual assessments of active members, with approval of the House of Delegates, to the Educational Fund and further, that the Board may establish additional terms and conditions regarding the Fund.

Chapter XIV, Section 1(a) page 29 of the current Bylaws provides for the Board to confirm the president elect's appointments to the various administrative councils.

Chapter XIV, Section 2(c) page 31 of the current Bylaws provides for the Board of Trustees to select members, other than the secretary, of the Committee on Medical Benevolence.

Chapter XIV, Section 2(d), page 31 of the current Bylaws provides for the Board of Trustees to select members of the Committee on Aid to Education.

Chapter XIV, Section 5, page 33 of the current Bylaws authorizes the Board of Trustees to determine the number of commissions and size of each after recommendations have been made by the appropriate councils.

This new section repeats the duties from all of the aforementioned sections, slightly reworded due to editing.

q. have the authority to combine the office of the treasurer in the event that the office is held by an individual, with that of the executive vice president.

r. review annually a budget for the expenditure of funds of this Society other than the disbursement of special funds then existing and may from time to time alter such budget as the needs of the Society shall require; such budget shall contain reasonable detail as to the allotment of funds in the various categories;

s. provide specific or general resolutions in order to authorize the treasurer to disburse monies in special funds if the disbursement is not provided for in these bylaws;

t. cause an audit of all accounts of the Society annually, with the authority to limit the scope and extent of an audit of the Medical Benevolence Fund; and report such audits to the annual meeting of the House of Delegates;

u. have the authority to approve affiliate membership applications;

v. appropriate a percent of the annual assessments of active members for the Medical Benevolence Fund and the Educational Fund in accordance with these bylaws;

w. have the authority to approve the appointments of the President-Elect to the various administrative councils;

x. have final determination in the number of commissions of administrative councils and size of each.

**Section 3 — Composition** — The Board of Trustees shall consist of the President, President Elect, the Vice President, the Immediate Past President, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, ex-officio with the right to vote, and one Trustee who is an active or associate member in good standing of this Society from each district.

**Section 3 — Composition** — Article VIII, Section 2, page 6 of the current Constitution describes the composition of the Board of Trustees. This new section repeats that provision and changes the speaker and vice speaker from ex-officio without the right to vote to ex-officio with the right to vote.

**Section 4 — Districts** — For purposes of this Society the counties in the Commonwealth of Pennsylvania shall be divided into the following twelve districts:

*First District* — Philadelphia County.

*Second District* — Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery counties.

*Third District* — Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne counties.

*Fourth District* — Columbia, Montour, Northumberland, Schuylkill, and Snyder counties.

*Fifth District* — Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York counties.

*Sixth District* — Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin counties.

*Seventh District* — Cameron, Clinton, Elk, Lycoming, Potter, Tioga, and Union counties.

*Eighth District* — Crawford, Erie, Forest, Mercer, McKean, and Warren counties.

*Ninth District* — Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango counties.

*Tenth District* — Allegheny, Beaver, Lawrence, and Westmoreland counties.

*Eleventh District* — Bedford, Cambria, Fayette, Greene, Somerset, and Washington counties.

*Twelfth District* — Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming counties.

**Section 4 — Districts** — Chapter XI, Section 1, page 24 of the current Bylaws describes the counties of Pennsylvania as they are divided into districts from which Trustees are elected.

This new section repeats the division of the counties according to districts and states that each district is entitled to one trustee.

**Section 5 — Nomination and Election of Trustees** — Nomination for a trustee shall be made by voting members of the House of Delegates from the district to be represented. Election by the whole House of Delegates is required.

**Section 5 — Nomination and Election of Trustees** — Article VIII, Section 3, page 7 of the current Constitution describes the method for nominating and electing a trustee and that no more than three trustees' terms shall expire at one time. (There is also a provision that the section at the time it was adopted did not cause unintended vacancies which is moot at this time.)

This new section repeats the nominating and election requirements only. (See next section.)

**Section 6 — Terms** — Each trustee shall be elected for a term of three years and may serve no more than three consecutive terms. A trustee elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than one year. A year is deemed to be the period of time between consecutive annual meetings of the House of Delegates.

Trustees' terms shall be arranged so that no more than four shall expire at an annual meeting of the House of Delegates.

**Section 6 — Terms** — Article VIII, Section 2, page 6 of the current Constitution, in addition to the composition of the Board of Trustees, explains the length of a trustee's term and also that a trustee may serve three consecutive terms.

Article VIII, Section 3, page 7 of the current Constitution, as previously mentioned, includes a provision that no more than three trustees' terms expire at one time.

This new section combines the provisions of both the aforementioned since they deal with the same subject but changes the provision from no more than three trustees' terms expiring at one time to "no more than four," to provide a balanced pattern of expiring terms.

**Section 7 — Vacancies in Trustees' Districts** — Within ninety days of a vacancy, the Board of Trustees shall appoint a member from the same district who meets all the appropriate qualifications to serve until the next annual meeting of the House of Delegates.

**Section 7 — Vacancies** — Article VIII, Section 4, page 7 of the current Constitution describes the method for filling a vacancy in an unexpired term of a trustee.

This new section retains the essential elements of the provision.

**Section 8 — Temporary Appointment** — In the event that a Trustee is unable to act, the Chairman of the Board, after consultation with the components in the district, may promptly appoint a temporary trustee from the same district who meets all the appropriate qualifications. At the next meeting of the Board of Trustees, if conditions are unchanged, the Board may continue the temporary appointment made by the Chairman, or the Board may fill the vacancy, if one exists, according to these bylaws.

**Section 8 — Temporary Appointment** — Chapter XI, Section 3, page 25 of the current Bylaws describes the conditions under which the chairman of the Board of Trustees may appoint a temporary councilor.

This new section repeats the essential elements with the new reference "Trustees" substituted for "Councilors."

**Section 9 — Duties of Individual Trustees** — Each trustee shall be the representative of this Society for his district and shall visit the components in his district annually and report on such activity to the Board of Trustees.

Each trustee shall help organize component societies where none exist, inquire into the status of the profession, increase the zeal of the components, and report annually to the House of Delegates regarding his work and the status of the professions in the components of his district.

Each trustee shall attend the meetings of the Board of Trustees and perform other such duties as may be assigned by the Board of Trustees.

Each trustee shall serve as chairman of all meetings of the District Board of Censors of his district in accordance with these bylaws.

**Section 9 — Duties of Individual Trustees** — Chapter XI, Section 2, page 25 of the current Bylaws describes general duties of councilors. Chapter XII, Section 1, page 25 of the current Bylaws designates each trustee as chairman of his District Board of Censors.

This new section repeats these essential elements, slightly reworded and adds the duties of the "Trustee" to attend meetings of the Board of Trustees and the House of Delegates. The provision that trustees be reimbursed for travel expenses is not included here.

**Section 10 — Board Officers** — At the first meeting of the Board of Trustees after the annual meeting of the House of Delegates, it shall elect a Chairman and a Vice Chairman to serve until the next such meeting of the Board and until their successors are elected.

The Chairman of the Board of Trustees shall preside at

**Section 10 — Board Officers** — Chapter V, Section 2, page 18 of the current Bylaws describes when officers are elected and who they are and gives the chairman appointment authority.

This new section repeats those provisions.

meetings of the Board, coordinate the work of the Board, and appoint the committees of the Board.

The Vice Chairman shall serve in the absence of the Chairman and perform such other duties as the Board may direct.

The Secretary of this Society shall serve as Secretary of the Board of Trustees.

**Section 11 — Vacancies in Board Offices** — Should the Chairman of the Board be incapacitated or unable to perform the duties of that Board office as determined by the Board of Trustees then the Vice Chairman shall act in his stead.

Should both the Chairman and the Vice Chairman of the Board be incapacitated or unable to perform their duties of office as determined by the Board of Trustees then the Board shall elect a chairman and a vice chairman from among its members to act in their steads.

**Section 11 — Vacancies in Board Offices** — There is no current provision for addressing this possibility. This new section stipulates the Board's authority in the event of such vacancies.

**Section 12 — Committees of the Board** — The Board shall have the following standing committees consisting of three or more members:

a. *Finance Committee.*

b. *Publication Committee,* to supervise the publication of the journal.

c. *Executive Committee.* The Executive Committee shall have only that authority given it by the Board.

The Board of Trustees from time to time may authorize special committees to aid it in its work, which report directly to it. The Board shall determine the duties and number of members, who need not be members of the Board of Trustees.

**Section 12 — Committees of the Board of Trustees** — Chapter V, Section 3, page 19 of the current Bylaws provides for standing committees of the Board of Trustees and authorizes the Board to establish special committees as needed.

**Section 13 — Meetings** — Regular meetings of the Board of Trustees shall be held immediately upon the conclusion of the annual meeting of the House of Delegates and at least quarterly thereafter at such time and place as the Board shall determine. The Board meeting following the conclusion of the annual meeting shall be referred to as the Reorganizational Meeting.

During the annual meeting of the House of Delegates, the Board of Trustees shall hold meetings as often as may be deemed necessary and all matters referred to it by the House of Delegates shall be reported on within twenty-four hours if so requested by the House of Delegates.

Special meetings of the Board of Trustees may be called at any time by the Chairman or by three members of the Board, provided that appropriate notice is sent to each member of the Board prior to the meeting.

**Section 13 — Meetings** — Chapter V, Section 4, page 19 of the current Bylaws requires meetings of the Board of Trustees including special meetings. This new section repeats this provision and explicitly terms the Board meeting following the conclusion of the annual meeting of the House as the "Reorganizational Meeting." The method for calling special meetings of the Board has been changed in this new section. The current provision requires a three day notice by telegram and/or a five day notice by mail. In many cases expediency dictates a less cumbersome and more contemporary method of calling a special meeting of the Board. This new section revises the method for calling the special meeting.

**Section 14 — Quorum** — Seven members of the Board of Trustees shall constitute a quorum.

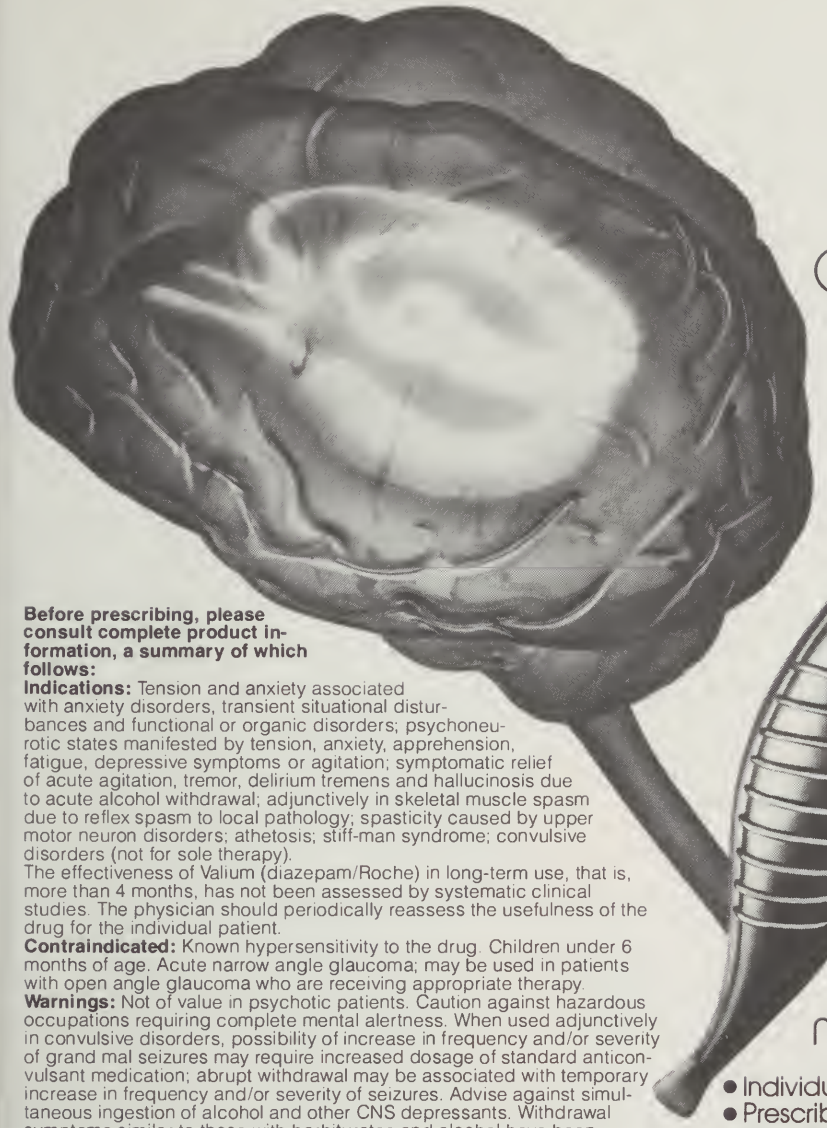
**Section 14 — Quorum** — Chapter V, Section 5, page 19 of the current Bylaws provides that seven Board of Trustees members constitute a quorum.

This new section repeats that provision.

**Section 15 — Publication of Actions** — The actions taken by the Board of Trustees shall be published in the first possible issue of the journal following the meetings thereof.

**Section 15 — Publication of Actions** — Chapter V, Section 6, page 19 of the current Bylaws requires the actions of the Board of Trustees be published in the journal of this Society.

This new section repeats that requirement, but in fact the proceedings are actions and the heading of this new section reflects that.



# Only Valium® (diazepam/Roche) is indicated in anxiety and tension states and as an adjunct in the relief of skeletal muscle spasm

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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## General guidelines for the prescribing and appropriate use of minor tranquilizers

- Individualize dosage for maximal beneficial effect.
- Prescribe the specific quantity needed until the next checkup period, schedule frequent, periodic reexaminations to monitor results of therapy.
- Establish treatment goals and gradually discontinue medication when these have been met.
- Avoid prescribing for individuals who appear dependency-prone or whose histories indicate the potential for misuse of psychoactive substances, including alcohol.
- Caution patients against engaging in hazardous occupations requiring complete mental alertness such as operating machinery or driving.
- Advise patients against the ingestion of alcoholic beverages while undergoing therapy with minor tranquilizers.
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- Caution patients against giving medication to others.
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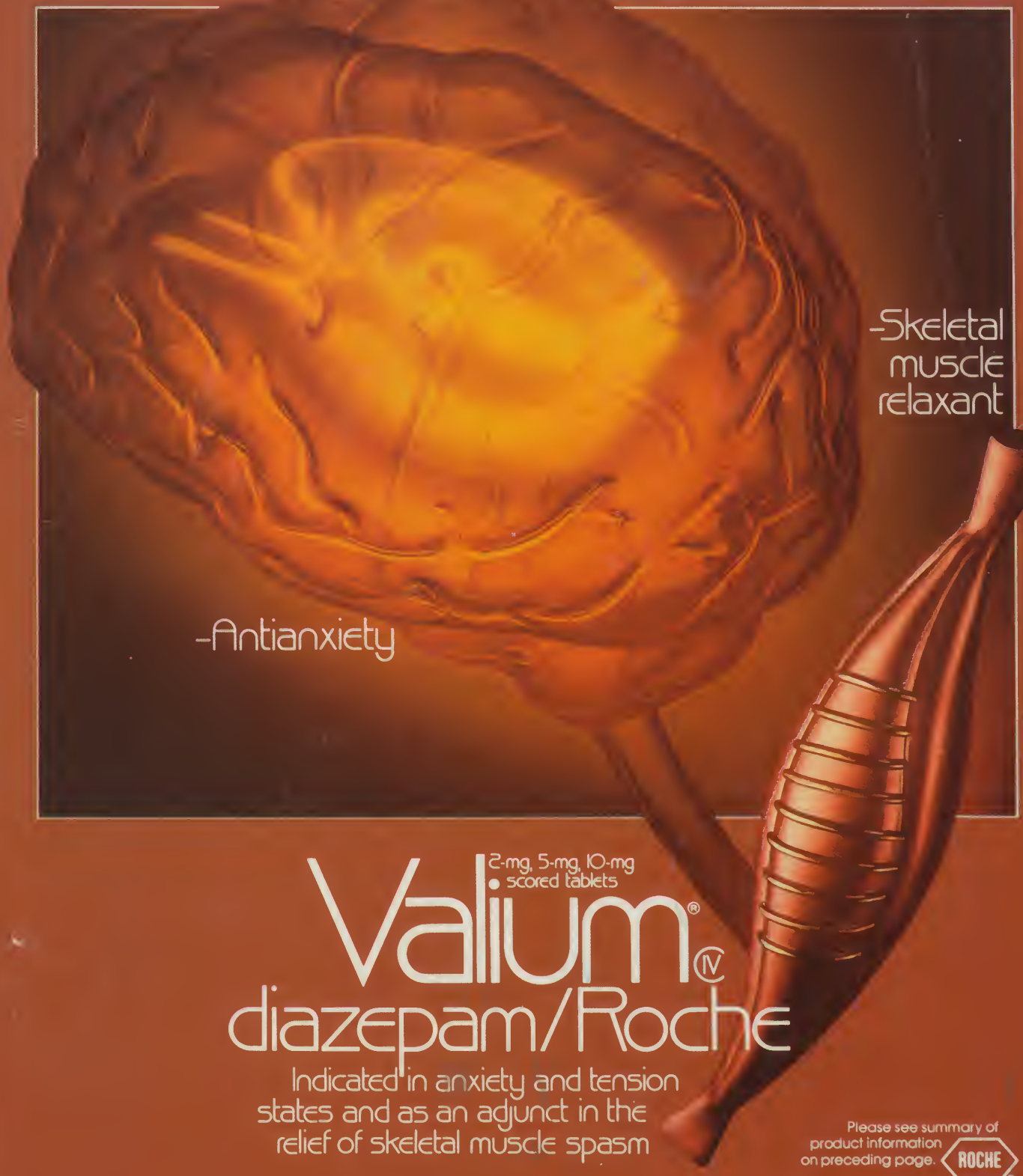


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# Pennsylvania Medicine

Vol. 83, No. 8 AUGUST 1980

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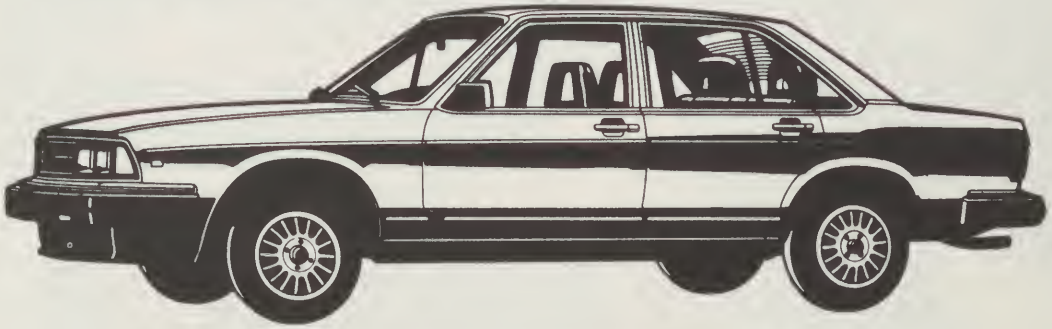

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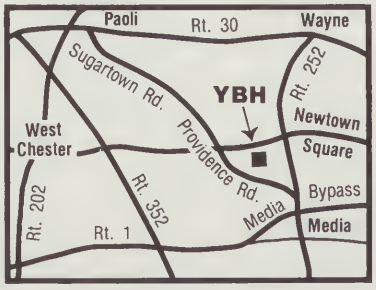


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MEDICAL PROTECTIVE WINS RATE INCREASE

The Insurance Department has approved rate increases for Medical Protective Co. in all territories effective September 1, 1980. The largest percentage of increase will affect physicians in Territory I (Philadelphia, Delaware, and Montgomery counties). Some 6,500 physicians will pay the premium increase, the second won by this professional liability insurer in a year. An overall increase of 13.5% was granted effective February 1, 1980. Here are the percentage increases by territory:

| Increase | Territory | |
|---|---|---|
| 30.9% | I | Philadelphia, Delaware, Montgomery Counties |
| 9.5% | II | Rest of State |
| 19.7% | III | Allegheny County |
| 16.4% | IV | Chester, Bucks Counties |

AMA HOUSE ADOPTS CODE, ELECTS NEW OFFICIALS

The AMA House of Delegates adopted a new code of medical ethics at the 1980 annual meeting in Chicago July 20-24. Robert B. Hunter, MD, of Sedro Woolley, Washington, was installed as AMA president. Three Pennsylvanians were among those elected to office. William Y. Rial, MD, of Swarthmore, was re-elected speaker of the House. Betty L. Cottle, MD, of Hollidaysburg, was re-elected to the Council on Constitution and Bylaws, and James B. Snow, Jr., MD, of Philadelphia, was re-elected to the Council on Scientific Affairs. George A. Rowland, MD, of Millville, was unsuccessful in his bid for re-election to the AMA Board of Trustees. John B. Lovette, MD, of Johnstown, is chairman of the Pennsylvania Delegation. More than 50 Pennsylvanians participated in the state caucuses. This number included the 22-member delegation, delegates from national specialty societies, council and committee chairmen, deans of medical schools, medical students, and residents. Details will appear in the September issue.

SOCIETY'S ANNUAL MEETING OCT. 31 IN PHILADELPHIA

The Annual Meeting of the PMS House of Delegates will be held at the Fairmont Hotel, Philadelphia, October 31 to November 2, 1980. The Official Call to the meeting appears on page 38 of this issue. This issue also contains the final installment of the proposed bylaws. A total bylaws revision is on the agenda of the 1980 meeting. The membership cards mailed this spring have an incorrect date for the 1980 Annual Meeting. Please correct your card to the dates shown above.

PMS URGES POLICY STATEMENT ON RADIATION MANAGEMENT

A policy statement on managing persons exposed to radiation was urged in a recent letter from PMS Board Chairman David J. Keck, MD, to the Department of Environmental Resources. Dr. Keck asked the department to cooperate with the Nuclear Regulatory Commission and the Pennsylvania Department of Health to prepare such a statement. It would serve as a guideline for hospitals, nursing homes, and other institutions. Recent inspections by the Joint Commission on Accreditation of Hospitals show that most institutions have no such policy.

MICHAEL L. BROWNE NAMED STATE INSURANCE HEAD

Governor Dick Thornburgh on July 1 nominated Michael L. Browne of Philadelphia as Insurance Commissioner, replacing Harvey Bartle, III. Browne began his duties as acting commissioner at the end of July. The permanent appointment requires Senate confirmation following the Legislature's summer recess. Bartle was named Pennsylvania's attorney general in May.

DPW TO HONOR MA BILLS FOR VACCINES SEPT. 1

A September 1 change in regulations will permit physicians to bill the Department of Public Welfare (DPW) for vaccines for patients on Medical Assistance. The rule will apply to all vaccines, even those costing less than $2.00. A contract between DPW and the Department of Health provides free vaccines to physicians until the new rule becomes effective. The interim contract and new rule became necessary when the Department of Health had to cancel its free vaccine program for budget reasons.

JOHN F. RINEMAN HEADS MEDICAL EXECUTIVES

PMS Executive Vice President John F. Rineman was installed as president of the American Association of Medical Society Executives July 19 in Chicago. AAMSE's 650+ members are executives of county, state, and specialty medical societies.

SUPREME COURT HEARS CASE ON ACT 111 ARBITRATION

The Pennsylvania Supreme Court again is mulling the constitutionality of Act 111 of 1975, the Health Care Services Malpractice Act. The case of Mattos vs. C. Fred Thompson challenges the constitutionality of the arbitration system established under the Act. The Society's legal counsel argued the case for the defendant.

NEW RABIES VACCINE AVAILABLE IN STATE

Limited amounts of the new FDA-approved human diploid cell rabies vaccine (HDCV) are available through the Pennsylvania Department of Health. The new vaccine, claimed safer and more effective, requires only five injections as compared with 23 injections of the vaccine currently in wide use. HDCV is available temporarily through the health department only for use in qualified situations, while commercial sources develop. The health department is limiting its use to rabies post-exposure prophylaxis in high risk situations. The local state health centers have details.

Pennsylvania Medicine

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**PENNSYLVANIA MEDICINE**
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

**PUBLICATION COMMITTEE**
Carol N. Maurer, MD, Chairman, Oil City
Ralph S. Blasiole, MD, Washington
John J. Danyo, MD, York
J. Mostyn Davis, MD, Shamokin
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**STAFF**
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Medical Editor
Mary L. Uehlein,
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**CONTRIBUTING EDITORS**
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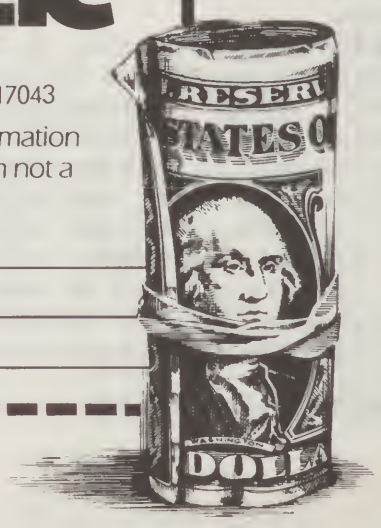

# editorial

## Reporting impaired drivers: preventive medicine

The automobile is an integral part of our modern, mobile society. Many of us would find it difficult to envision restrictions on or prohibition of driving. Yet we must remember that, despite its great convenience, the automobile can be an instrument of death and destruction when piloted by an impaired driver.

Impairment is most often thought of in terms of intoxication but it can include a number of other diseases or disabilities and could result in catastrophe. Physicians have an obligation to report contagious diseases which are a threat to public health. Now we are being asked to report conditions which may result in accidents due to a driver's physical or mental impairments.

The revised Pennsylvania Motor Vehicle Code of June 1976 contains a section (1517) creating a Medical Advisory Board and a section (1518) providing for the reporting of mental or physical disabilities which would impair an individual's ability to drive.

Physicians must comply with the reporting. The General Assembly is considering, but has not yet adopted, HB 425 which would apply the reporting requirements only to mental hospitals and alcohol and drug treatment facilities. Failure to do so could result in a criminal penalty. In at least one case in another state, the examining physician was held legally and financially responsible for the accident of a person he examined because he failed to meet the reporting requirements.

The Medical Advisory Board consists of thirteen members including a neurologist, an internist, a general practitioner, an ophthalmologist, a psychiatrist, an orthopedic surgeon, a cardiovascular specialist, an optometrist, and representatives from several state departments and agencies. This board has established a list of diseases, disorders, and disabilities which must be reported to the Department of Transportation if the person is over the age of 15. The reports must be submitted in writing within ten days of diagnosis.

Among conditions identified as reportable are visual deficiencies. Most states have minimum standards for visual acuity when driving. Road signs and mileage postings are designed to meet these standards.

Epilepsy is a reportable disease, and the circumstances under which an epileptic may drive are carefully spelled out. In 1978, at least nine other states required the reporting of epilepsy under their motor vehicle codes.

Other reportable disorders, if the physician judges the conditions would interfere with control of a vehicle, include:

- Loss or impairment of the use of a foot, leg, finger, thumb, hand, or arm, as a functional defect or limitation.
- Unstable or brittle diabetes or hypoglycemia, unless there has been a continuous period of at least six months' freedom from any related syncopal attack.
- Cerebral vascular insufficiency or cardiovascular disease (including hypertension) with accompanying signs and/or symptoms.
- Periodic loss of consciousness, attention, or awareness from whatever cause.
- Rheumatic, arthritic, orthopedic, muscular, or neuromuscular disease.
- Mental deficiency or marked mental retardation in accordance with the International Classification of Diseases.
- Mental or emotional disorder, whether organic or functional.
- Use of any drug or substance (including alcohol) known to impair skill or functions, even if the drug or substance is medically prescribed.
- Any other condition which, in the opinion of the examining licensed physician, could interfere with the ability to control and safely operate a motor vehicle.

A paper entitled "Road accidents and the unfit driver," which appeared in the *British Medical Journal* in 1978 (*2:*1471-1473) cited sudden illness as a cause of one to two accidents per 1,000 and chronic conditions as a cause of as many as five per 1,000. A study in the *Journal of the American Medical Association* (*205:* 266-271, 1968), entitled "Natural death at the wheel" said 15 percent of drivers dying within 15 minutes of an accident were shown to have coronary heart disease or other serious illness. "Accident and violation rates of Washington's medically restricted drivers" (*Journal of the American Medical Association 205:*272-276, 1968) said "Drivers with diabetes, epilepsy, fainting, and other diseases necessitating licensing restrictions have statistically higher accident rates than the population of Washington drivers."

I report this to the membership partly to support the legislative intent. More importantly, however, my purpose is to inform you that we now have legislative requirements which call for stiff penalties for violations. In light of this, all physicians doing such examinations should have copies of the medical provisions of this law available in their offices. Copies can be obtained from the Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043.

David A. Smith, MD
Medical Editor

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# PMS leaders focus on health care of the poor

Consumerism is a newcomer to the Pennsylvania Medical Society. It was just at the November 1, 1979 meeting of the PMS House of Delegates that Matthew Marshall, Jr., MD, then president elect, charged the society to become an aggressive consumer advocate.

Dr. Marshall recommended that 1980 be the year of the health care consumer. He said, "Now is the time for us collectively through our medical society to listen to representatives of labor and organized minority groups. If we try to understand what they are saying and convince them that we are not using them, we can work together to better serve their constituents and our patients."

One step toward achieving that understanding was taken at the 1980 Officers' Conference held April 23-24. Dr. Marshall, PMS president, moderated a panel discussion of the disadvantaged health care consumer.

---

*Carl Moore, chairman of South Philadelphia Health Action, participated as a panelist. He is a long-time consumer advocate of health care in Philadelphia. His remarks follow.*

Your discussion focuses on an interesting subject, interesting for several reasons. First, it is interesting to me as a resident of an inner city community. Secondly, it is interesting because of its importance to thousands of Pennsylvanians who, like me, are residents of inner cities and who lack appropriate and high quality health care. Thirdly, it is interesting becasue the subject is not new. The problem of quality health care in the inner city has been the subject of discussion and federal investments for more than two decades now.

**Background**

In preparing my remarks, I looked through my collection of relevant materials and found the 1969 report of the National Health Forum. This report dealt specifically with health care problems in the inner city.

As I read the report, I was reminded that already it was 11 years old. The language was optimistic. The times seemed ripe for tapping all the resources necessary, including money and manpower, to meet any problem, including the inner city health care problem. It sounded as if ample federal and state funds and a convincing degree of private sector support were available to change the traditional medical care system.

Equally interesting but more bothersome was the number of recommendations made at the 1969 Conference still on our social agenda today. This workshop suggests a healthy measure of *déjà vu*.

The lack of progress since 1969 was certainly not attributable to the lack of representation by the movers of the medical community. Some of the people who attended the 1969 National Health Council are still fighting to improve inner city health care. My own community had several representatives there including consumers and providers.

The former City of Philadelphia Health Commissioner, Dr. Norman Ingraham, attended as well as Bob Cathcart who went on to chair the American Hospital Association. Congressman Conyers and the first head of the New York City Health and Hospitals Corporation attended. The attendance list read like a page from who's who in medicine.

The recommendations that resulted from the 1969 Conference warrant attention. One set dealt with payment for medical services and among various other recommendations called for a national standard to be set for medicare and medicaid. Another called for

establishing a national comprehensive system of health insurance for all. A third suggested that federal funds be more heavily weighted toward meeting the health needs of the poor. Today we hear that the state medicaid program is running dry and we have already seen the butchering of the inner city federal funding programs under the knife of federal budget cutters.

A second set of recommendations called for developing community comprehensive health centers with emphasis on team practice and prevention. Hospital emergency rooms and outpatient clinics were recommended as future microhealth centers to serve the needs of the inner city. Although neighborhood health centers have developed, as the federal funds that supported them evaporated, they were replaced by the modern medicaid mills. In my community we call these the Green Thumb medical centers. The lucky patients see a physician for several minutes at the most but, nonetheless, leave with a handful of prescriptions. Certainly, there is no shortage of these Green Thumb medical centers. The questionable factor is the quality of care rendered.

Another section dealt with health manpower; it called for special recruitment programs from the inner city communities. Today, we hear that we have produced too many physicians. Now, we must sit by and watch as cutbacks are made in HHS stipends to support medical and nursing student personnel.

The Pennsylvania Medical Society is not to be blamed for today's problems of inner city health care. These problems have been with us for many years and have received the dedicated attention of many important people. This workshop focuses attention on the continuing plight of my community and other inner city communities throughout this Commonwealth. Despite all our previous efforts, we are forced to recognize the sobering reality that so much remains to be done in improving the quality and quantity of health services available to our inner city residents and the rural poor of our state.

**Goals**

The problems of inner city health care are not the sole responsibility of PMS, nor could the Society be the sole solution, but, the support of PMS and its members is crucial to any ongoing struggle for improved inner city health care. I feel PMS can exert a valuable influence at policymaking levels in government and throughout the private health care system. This would be a big step toward solving the health care problems of the inner city community.

Recruiting minority students and providing them with incentives to establish high quality medical practices in our inner city communities need more attention.

Medical schools should develop channels of communication and exposure for their impressionable students. There are exciting examples of successful inner city private medical practices. As an example, in my community, Dr. Walter P. Lomax practices in South Philadelphia. He has excellent physical facilities and retains first rate personnel at all levels.

## Penn State schedules telecasts of continuing education courses

The College of Medicine and the Department of Independent Study by Correspondence of Pennsylvania State University have scheduled telecasts of the 1980-81 "Physician Update" programs.

"Physician Update" is a series of half-hour television programs exploring current medical topics. Physicians can earn one hour of Category I credit toward the AMA's Physician's Recognition Award by watching the programs and answering the questions in the registration brochure. The series features faculty from Pennsylvania State University, University of Pittsburgh, and Temple University.

**Matthew Marshall, Jr., MD, PMS president (right) and John F. Rineman, executive vice president (left) met with Governor Dick Thornburgh June 10, 1980. The PMS delegation discussed the inequities of medicaid reimbursements to physicians and the Society's dislike of the proposed DPW "provider agreement." The Governor pledged to settle the lawsuit against the Commonwealth concerning the use of physicians' fees by the State Board of Medical Education and Licensure.**

The programs are broadcast on WPSX-TV, channel 3, which serves 28 counties in the central Pennsylvania area. PENNARAMA, the state's continuing education cable television service, presently serving Lackawanna, Luzerne, and Wyoming counties, also will telecast the series.

Interested physicians should check local listings beginning September 15. "Physician Update" is not available throughout the state, but physicians can earn credit by viewing many of the programs on videocassettes.

For additional information on videocassette rentals or scheduled broadcasts, write: Physician Update, Jerry Sawyer, Pennsylvania State University, Wagner Annex, University Park, PA 16802; or call (814) 863-0478.

He is affiliated with an HMO and is involved in teaching programs of the University of Pennsylvania. He has staff privileges at several hospitals, and he is active in our community.

We must find more Dr. Lomaxes and, in fact, we must find ways to encourage more Walter Lomaxes of the practicing physicians of today so that our young physicians of tomorrow can follow in their inner city footsteps. Problems of security and professional life style will always be major drawbacks, but these same problems are beginning to confront the practitioner in more affluent suburban communities.

By working closer with our local communities I believe that it is possible to convert some of those who would question, *"Why should I practice here?"* to thinking *"Why not?"*, particularly when we can provide the incentivies to persuade the young physician to begin his professional career in the inner city. Again, we must identify the Walter Lomaxes, the inner city successes, and build upon them. We should not continue to spread the word about how impossible it is to practice in the inner city.

The Pennsylvania Medical Society through its policymaking and influence can bring pressures to bear to see the expansion of home care and geriatric programs. There is an ample supply of short term acute care in my community but little, if any, geriatric or long term care.

A final and more difficult goal for PMS is that of policing those physicians who today operate in the inner city. These physicians are not always working to enhance modern medical science, nor are they necessarily dedicated to the needs of their communities. More likely they see a good thing and are milking it for all it is worth, and, it is worth plenty! Their patients are the victims, not the benefactors, of modern medical care.

These operators give medical centers in our inner city communities so bad a name. They chase away the young and more dedicated medical professionals who might otherwise establish their practices in our inner city communities. We must not allow these physicians to continue to cheat us of the care we deserve.

As consumers, or even as patients of these physicians, we cannot exert the necessary controls by ourselves. We need PMS to fight for us. We need PMS to fight for greater peer review both in the hospital and outside. We need PMS to be prepared to make unpopular judgments when physicians, operating below accepted quality standards, are identified.

**Conclusion**

I live with the problems of inner city health care every day so I am pleased that PMS chose to focus its attention on solving them. The problems of inner city health care, like many other inner city problems, will not be easy to solve. Already we have worked years and still much remains to be done. But, I am convinced that as the powers in medicine and the grass roots leadership throughout inner city communities continue to work together, someday we will accomplish the many recommendations necessary to bring about lasting and quality im-

## New budget increases fees for services to medical assistance patients

The Thornburgh Administration's 1980-81 budget increases fees to physicians participating in the state's Medical Assistance program. The new budget increased fees to physicians for office visits from $6.00 to $8.00 at an estimated annual cost of $9,950,000 ($5,700,000 state funds).

The fee increases became effective July 1, 1980. Seven other groups of medical providers who serve the elderly, poor, and disabled also began to receive increased fees.

An estimated $63,164,000 in state funds will pay the increases to physicians, dentists, pharmacists, podiatrists, outpatient clinics, hospital home care, home health services, and nursing homes. Combined with federal matching funds, the fee increases will total an estimated $130 million annually.

### Physician suspended from MA program

The state department of public welfare suspended Amleto Acquaviva, MD, New Castle, from participating in the medical assistance program for three years. Dr. Acquaviva had billed for services that were not provided in the amount of $100,000 for calendar year 1979.

Other abusers who were terminated from the program included two chiropractors, two dentists, one nursing home administrator, and two pharmacies. The eight medical care providers had a combined annual billing of approximately $265,000.

### Chest physicians to hold annual meeting in Boston

The American College of Chest Physicians will hold its 46th Annual Scientific Assembly at the Sheraton Boston Hotel/Hynes Auditorium Convention Center, October 26-30, 1980.

The five-day meeting will feature five postgraduate courses including, "Clinical Applications of Two-Dimensional Echocardiography," "Disability Assessment in Lung Diseases," "Critical Care," "Perfusion Technology," and "Interdisciplinary Care of the Ventilatory Dependent Patient."

Four of the programs will be presented on Sunday, October 26; the fifth program will convene on Tuesday, October 28. All programs will be held at the Sheraton Boston Hotel.

For further information, contact: Department of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

### Thoracic physicians plan September meeting

The 43rd annual meeting of the eastern section of the American Thoracic Society will be held September 26, 27, 1980 in Wilmington, Delaware at the Hotel DuPont.

Highlight of the meeting will be a lecture on sleep apnea by Dr. Eliot A. Phillipson, professor of the medicine department at the University of Toronto. A symposium entitled "Is exercise testing useful?" will be featured on the second day.

For additional information and reservations, contact the Delaware Lung Association, 1308 Delaware Avenue, Wilmington, DE 19806, or call (302) 655-7258.

provements to the thousands of Pennsylvanians who live in the shadows of our medical schools, teaching hospitals, and other major community institutions.

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*Arthur J. Edmunds, executive director of the Urban League of Pittsburgh, Inc., also participated on the panel. He is president of the Pennsylvania Council of Urban Leagues. His remarks follow.*

This portion of your agenda, an airing of consumer concerns, is a first for the Pennsylvania Medical Society. As I see it, it is an opportunity to open a line of communication which, unfortunately, has been overlooked for far too long.

Having known Matt Marshall for many years, knowing his long-standing commitment to consumer involvement in health and welfare planning and knowing that he has long been the only white member of the Gateway Medical Group in Pittsburgh, I know that the overture is sincere. I hope that, today, we will begin what will become a continuing dialogue, perhaps at times a coalition, between organizations and people who have more in common than most of us suspect.

Let me reassure you that I, for one, do not feel at all out of place here. I have had more than a passing acquaintance with the medical profession. As the son, the husband, and the father of registered nurses, I have been involved in health care, in a sense, since the day I was born.

I have served on the board of Matt's own hospital and of Hospital Council of Western Pennsylvania, the state Examining Board of Nursing Home Administrators, and the new state Health Care Policy Board. What is more, during the football season, I am a regular patron of the Allegheny County Medical Society's Sunday Steeler brunches. I can say, quite literally, that some of my best friends are physicians.

One of those friends, a black family doctor, tells the story about the white patient who came to his office shortly after he started his practice, some twenty years ago. Surprised to discover that the doctor was black, the patient asked nervously, "Do you . . . uh . . . take . . . uh . . . *white* patients?" "They only print one set of medical books," he retorted as he ushered her into the examining room.

**Discrimination**

You know, of course, that underneath the different skin colors, the human body works the same way. (That is why they call it "*Gray's* Anatomy," isn't it?) And you know that disease does not discriminate. In fact, I am told, now that blacks are moving into more stressful executive positions and gaining access to better diagnostic care, even heart disease and cancer have become equal opportunity entities.

I hope you also know that black people and poor people prize life just as highly as do your other patients. Caring for a sick baby, a senile patient, a terminally ill spouse are experiences every bit as traumatic to a medicaid patient as they are to the middle-class suburbanite or to a member of your own family.

There is, however, one important difference: the poor patient (and particularly the poor black patient) is probably much more frightened and apprehensive of the health care system than is his white middle-class counterpart. Because of the discrimination in the past (and even now) . . . discrimination which *you* personally had nothing to do with—but which


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meant that some people had less chance to survive or to get well, had less chance even to get care, and had a better chance of being subjected unknowingly to experimentation . . . because of all this, the health care system (and particularly the hospital) can be a terrifying experience. It is still more terrifying when not only all the *uniforms* but also all the *faces* are white. (How would *you* feel, for example, as a patient in a hospital where all the doctors, nurses, administrators, and technicians were *black*?)

**Challenges**

This presents a special challenge to the white physician. I hope that you can see it as a challenge, not as a burden or, worse, as an insult or an accusation. Individually, it means that you may need to be a bit more personal, more reassuring, and even more informative. Professionally, it means that all of us who have anything to do with the health care system should see to it that our institutions and personnel are sensitive to the needs of *all* patients.

It also means that we must move consistently in the direction of a single track system of care for all. We have abolished, for the most part, charity wards as such largely because medical assistance reimburses hospitals at full (or near full) cost. But we continue, in many areas, to segregate our poor into separate facilities, such as public hospitals, county homes for the elderly, clinics, and emergency rooms, often inefficiently and at far greater cost than in facilities which serve the nonpoor. The Supreme Court has not yet ruled on this kind of segregation, but I maintain that separate is, by its nature, *not* equal, in health care as well as in education.

What can we do about it? Individually, probably not a great deal, but jointly, who knows?

We all know that the main reason many poor people wind up in the emergency room for their primary care is because medical assistance does not pay you enough to cover even the cost of the required paperwork. We do not ask the supermarket, or the department store, or the landlord to subsidize the welfare recipient. Why then do we expect private subsidy from doctors, pharmacies, and nursing homes?

If you plead the case for higher reimbursement alone, you will be accused of avarice.

If we do it alone, we will be dismissed as bleeding hearts or nonprofessionals.

But if we join forces and draw in our respective allies (Welfare Rights, Legal Services, and NAACP from our side; nurses, professional societies, and the corporate sector from yours), we would get the attention of the legislature, if, for no other reason, merely out of the shock of seeing us on the same side!

Join with us in pressing for a more reasonable and equitable reimbursement for long-term care so that our elderly poor of both races can find something better than a cot in the basement of a boarding home and we will have both the private nursing homes and their frequent adversaries, the patient advocates, with us, too.

Help us persuade the legislature to require full disclosure of financial and employment data by hospitals as a basis for a real community-wide effort to contain health care costs and make good on the promise of equal employment opportunity, and we will have virtually every consumer and civil rights group in the state in our corner.

**Conclusions**

These are our prime concerns currently in health care. Most of them are issues which, I would imagine, *you* also could support. Perhaps you as individuals and as a society have other concerns which community organizations like the Urban League could support.

Of course, there will be areas in which we will disagree, but in those, I am confident that we can, in mutual respect, simply agree to disagree. I do agree wholeheartedly with Matt, however, that it is time we began talking with each other and moving ahead, united, to bring about those changes which we all feel must be made.


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# Federal funds for state's feeding program threatened

The state health department's federally funded $31.5 million women, infants, and children (WIC) program is in danger of losing a portion of its grant money. The program, which provides food packages to eligible pregnant or breastfeeding women and to children less than five years old, currently supplies basic nutritional needs to about 75,000 Commonwealth residents.

H. Arnold Muller, MD, state health secretary, said that between $2.75 million and $8.56 million may have to be returned to the U.S. Department of Agriculture, Food, and Nutrition Service on September 30 when the 1980 federal fiscal year ends. According to Dr. Muller, not enough women and children who are eligible to receive benefits from the program are aware that they qualify for monthly aid in the form of milk, cereal, eggs, cheese, and juice.

Dr. Muller told a Harrisburg press conference June 25, 1980, "I consider this to be the disaster of 1980. The disaster of 1980 is a mother experiencing the feeling of having no money to purchase milk for her infant, or watering down milk to fill an 8 ounce bottle.

"The disaster of 1980 is a small child being given a breakfast of a candy bar and a glass of water instead of orange juice, a bowl of cereal, and an egg.

"The disaster of 1980 is a needy, desperate mother being arrested for shoplifting food because she is unaware that such food is available to her and her young children through the WIC program.

"The disaster of 1980 will not sell newspapers or make the national news, but this disaster is as equally damaging to those who need help as it was to those affected by the problems of past years in Pennsylvania.

"WIC is a vital program for those Pennsylvania women and children certified to be at a nutritional risk due to inadequate income and nutritional needs. To have even one mother or her child without milk, cereal, eggs, juice, or cheese when she is eligible to receive them through the WIC program . . . that, to me, is the disaster of 1980.

"This department is beginning an intensive public information campaign to assure that every qualified woman or child in this Commonwealth is aware of the benefits available through WIC.

"I can assure you, as secretary of health, that future federal funding for this program will be used to its utmost here in Pennsylvania before even one penny reverts to Washington."

Physicians are in a position to help in this public information campaign. Patients who are eligible through nutritional risks are those with such conditions as anemia, growth failure, obesity, or other nutritionally related medical conditions. The infant of an alcoholic, mentally retarded, or drug addicted mother also is considered in granting eligibility. Dr. Muller said that collecting welfare assistance in no way prohibits a woman from receiving WIC supplements if she meets the criteria for eligibility.

Dr. Muller concluded, "We simply have to make an effort to make every Pennsylvanian aware of this vital nutritional program available in all 67 counties of the Commonwealth."

**John B. Lovette, MD, (left), and Hoyt D. Gardner, MD, (middle) received Legions of Honor in Bronze from the Chapel of Four Chaplains, Temple University, Philadelphia on May 25, 1980. William Y. Rial, MD, presented the awardees at the interdenomination chapel named for four chaplains of three faiths who died when the *S.S. Dorchester* was torpedoed during World War II.**

## Family physicians install Dr. Davis as president

The Pennsylvania Academy of Family Physicians installed J. Mostyn Davis, MD, as 34th president at its annual convention and scientific assembly held at Mt. Airy Lodge, Mount Pocono, June 17-22, 1980.

Dr. Davis has been in the solo practice of family medicine for 23 years. He opened his office in Shamokin shortly after he had finished a one-year internship at Geisinger Medical Center. He received his medical degree from Jefferson Medical College in 1956.

He joined the Academy in 1958 and has since served as secretary, member of the board of directors, chairman of the commission on membership and credentials, editor of *Keystone Physician,* and chairman of the publication committee.

Past president of the Northumberland County Medical Society, he now serves as trustee and councilor of the 4th Councilor District of the Pennsylvania Medical Society.

He is an active staff member of the Shamokin State General Hospital and a volunteer faculty member of the Family Practice Residency Program at Geisinger Medical Center.

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# Physician's license suspended for medicare fraud

**Fred Speaker, Esq.**

The Commonwealth Court has ruled recently that a physician may have his license suspended for fraud in submitting medicare bills.[1]

The physician had been convicted of the misdemeanor of presenting false claims for reimbursement under medicare. The physician also had treated two undercover narcotics agents for weight control. He prescribed controlled drugs to suppress their appetites without conducting adequate physical examinations, monitoring the treatment, or maintaining proper medical records.

The Medical Practice Act empowers the State Board of Medical Education and Licensure to revoke or to suspend a physician's license for reasons including making fraudulent representations in the practice of medicine[2] and for being guilty of unprofessional conduct.[3] A three-member panel of the Commonwealth Court held that it was a violation of the Medical Practice Act to submit fraudulent bills even to third party payors. The Court said:

> It seems clear to us that billing third party payors is within the doctor-patient relationship when a patient becomes the tool of a physician's fraud. The mere substitution of victims does not take the activity outside the scope of Section 15(a) (2). If Petitioner's logic were to be accepted, a doctor could not be disciplined for fraud in billing a child's parents for services rendered to the child because the parents are outside the doctor-patient relationship. Such a result is patently absurd and Petitioner's argument must be rejected.[4]

The Court also held that the inadequate treatment of the undercover agents constituted grounds for loss of license because of unprofessional conduct. The Court however held that the fraudulent billing under medicare did not constitute unprofessional conduct. The Court stated:

> The legislature defined the term "unprofessional conduct" in subsection (a) (8). We can neither ignore nor expand upon that definition. We do not attempt here to identify what unprofessional conduct would be in all situations, but we do hold that Medicare fraud is not within the scope of Section 15(a) (8).[5]

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*

1./ *Catena, M.D., v. Commonwealth of Pennsylvania, State Board of Medical Education and Licensure,* 411 A. 2d 869 (Pa. Commonwealth Ct. 1980).

2./ Making misleading, deceptive, untrue or fraudulent representations in the practice of medicine; practicing fraud or deceit in obtaining a license to practice medicine and surgery; or making a false or deceptive biennial registration with the board. 63 P.S. §421.15(a) (2).

3./ Being guilty of immoral or unprofessional conduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, in which proceeding actual injury to a patient need not be established. 63 P.S. §421.15(a) (8).

4./ *Catena, M.D., v. Commonwealth of Pennsylvania, State Board of Medical Education and Licensure, supra* at 871.

5./ *Id.* at 872.

# Court upholds consent-to-rate insurance forms

**Daniel J. Menniti, PhD, JD**

Two physicians, obstetrician/gynecologists, filed an appeal with Commonwealth Court after receiving an adverse decision from the Pennsylvania Insurance Commissioner regarding their insurance carrier, Pacific Indemnity Company.

The insurance company had filed in 1975 for a rate increase which the commissioner disapproved. But the company instituted a "consent-to-rate" procedure pursuant to 40 P.S. Sec. 1184 (g) which provides:

> Upon the written consent of the insured stating his reasons therefore, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk. The rate shall become effective when such consent is filed and shall be deemed to meet the requirements of this Act until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect.

The commissioner allowed the company to use the form because of the possibility that the company would withdraw from the malpractice market.

The physicians then filed a complaint with the Insurance Department. They challenged the use of the forms and asserted that theirs was a class action complaint on behalf of all obstetricians and gynecologists similarly situated. The commissioner rejected their complaint.

In their appeal, the physicians argued that they were entitled to assert class standing and that the company's use of the forms violated both the Casualty and Surety Regulatory Act (see *supra* 40 P.S. Sec. 1184) and the requirements of due process. Commonwealth Court, in an opinion by Judge Blatt, affirmed the decision of the commissioner.[1]

The Court rejected the assertion of a class-action suit because the Pennsylvania Administrative Code provided for intervention of interested parties and consolidation of proceedings on similar issues.[2] The Court denied that "the right to assert class standing in

*The author is associated with Pepper, Hamilton & Scheetz, legal counsel to the Pennsylvania Medical Society.*

**The order of the Chester County Court in *Commonwealth v. McKay* reported in "Court rules right of privacy not absolute," published in the April 1980 issue of PENNSYLVANIA MEDICINE, was affirmed by the Commonwealth Court on June 4, 1980.**

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an administrative hearing should be inferred." It stated that there was no evidence that applicable administrative procedures were inadequate.

As to the argument that the consent-to-rate forms violated the Act, the Court held that the commissioner in no way abused his discretion in allowing the widespread use of the forms. The Act allows for using the forms but does not define such use. The Court, therefore, held that the use of the forms falls within the discretion of the commissioner.

The Court rejected the due process argument of the physicians because all the involved insureds had been sent notices and had had an opportunity to be heard.

This case reminds all those dealing with administrative agencies that there are specific rules for proceedings and also that, in the absence of such, the good use of discretion by the agency is normally upheld on appeal.

---

1./ *Andrew Sullivan and Edward Sullivan v. Commonwealth of Pennsylvania, Insurance Department and Pacific Indemnity Company*, 408 A. 2d 1174 (1979) Pa. Commonwealth Ct.

2./ 1 Pa. Code 31. 1 *et seq.*

## New psychiatric program at Friends Hospital

An alternative to traditional psychiatric care programs will be available this fall as Friends Hospital begins its new program, Greystone House.

Greystone House will offer a structured environment and professional guidance for patients who are not progressing in conventional psychiatric treatment. James M. Delaplane, MD, director of Friends Hospital, said the program will encourage and assist residents in reaching their highest capabilities.

Greystone House will accommodate 13 residents, age 21 and older, who are in good physical health and free of destructive behavior. The daily rate will be $80. Residents are expected to remain at Greystone House a minimum of one year.

For more information on the program, or to recommend a potential resident, telephone Dr. Delaplane at (215) 831-4601, or Greystone House Director Diane Attenborough, RN, MSN, at (215) 831-4779.

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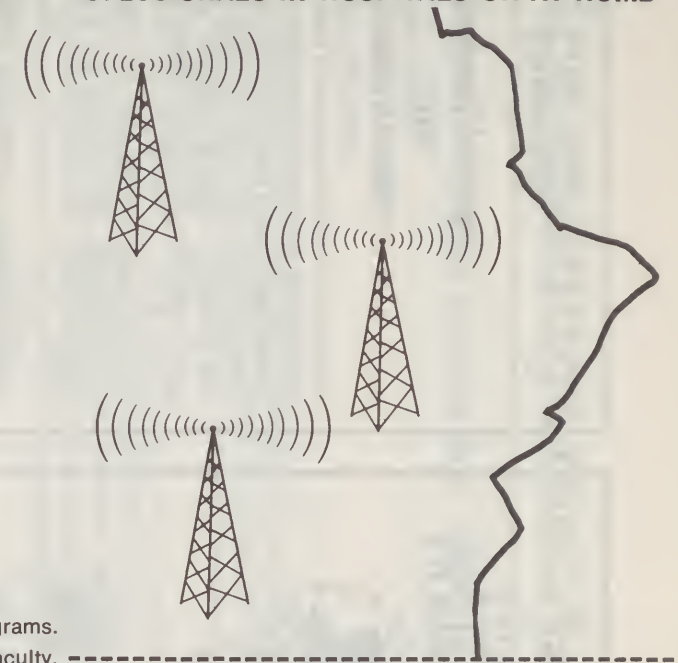

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# Corporate retirement plans for 1980

**Leif C. Beck, LL.B., CPBC**
**Vasilios J. Kalogredis, JD, CPBC**
**Geoffrey T. Anders, JD, CPA**

Various types of corporate retirement plans are available. Our discussion of the different plans should serve as useful background information for physicians evaluating the incorporation step. The article also may prove equally valuable as an update for those who are incorporated, including those who are considering a change in their present retirement plans.

**Defined contribution plans**

There are three major types of defined contribution plans available to the incorporated professional: (1) money purchase pension plan; (2) profit sharing plan; and (3) target benefit pension plan. Each will be described in detail.

1. *A money purchase pension plan* is a corporate retirement plan requiring the corporation to contribute a specific formula each year for then-eligible employes. For example, a money purchase pension plan could call for an annual contribution equal to ten percent of compensation for each participating employe. The corporation must make that contribution; it is obligatory.

The maximum amount which may be contributed for any employe for the 1980 plan year in a money purchase pension plan is the lesser of 25 percent of total corporate compensation or $36,875. The dollar figure increases annually with cost-of-living. In 1974 it was $25,000; in 1979 it was $32,700. Therefore, should a doctor's 1980 corporate year salary exceed $147,500 (25 percent of which is $36,875) the corporation could not contribute a full 25 percent on his behalf.

Each participant has an individual account balance and, if the plan so allows, each participant can separately invest his portion of the fund. This is unique to the defined contribution plans.

2. *A profit sharing plan* is another type of defined contribution corporate retirement plan. Generally, contributions to a profit sharing plan are limited to current or accumulated corporate profits.

A profit sharing plan differs from a pension plan in that contributions to it are not obligatory, they are discretionary. The corporation board of directors, usually the doctor(s) and key advisors, makes the final contribution decision. Such a plan provides excellent flexibilities.

The maximum contribution limit for a profit sharing plan is 15 percent of the covered employes' compensation. This allows the board the flexibility to authorize a contribution as low as $0 or as high as the above described 15 percent.

A common arrangement for many professional corporations involves combining a profit sharing plan with a money purchase pension plan. The two combined can allow corporate contributions as high as the 25 percent or $36,875 described above. Although a money purchase pension plan alone could allow for such a generous contribution, the flexibility the profit sharing plan provides often has great appeal over the rigidity of a full 25 percent money purchase pension plan formula.

3. *A target benefit plan* is a hybrid. It is a defined contribution plan with some defined benefit characteristics. It is rarely used but can be advantageous in certain situations.

Under such a plan, the amount of the employer contribution allocated to each participating employe is determined under a formula that does not allow discretion by the corporation. It is computed on the basis of the amount necessary to provide a target benefit figure at the specified retirement age for the participant. Age, number of years to retirement, life expectancy at retirement, compensation, and assumed investment returns are all factors used in the calculations. The plan provides a formula benefit (e.g. 50 percent of monthly compensation) for retirement without committing to achieve that goal. Depending on investment results, the plan may fall short or may exceed the target benefit goal. An actuary is needed to calculate this.

The maximum amount that may be contributed for any participating employe under this plan is the lesser of 25 percent of compensation or $36,875 in 1980.

**Defined benefit plan**

An easy definition of a defined (or fixed) benefit pension plan is that it is not a defined contribution plan. It resembles a target benefit plan except that it is not subject to the 25 percent/$36,875 limit; each participant does not have an individual account; and the benefit provided for in the plan as being available at retirement is a commitment.

The limitations on defined benefit plans are not expressed in terms of a *maximum contribution* per year; they are expressed as a *maximum retirement benefit* being sought. The 1980 defined benefit limitation requires that the annual benefit per participant cannot exceed the lesser of $110,625 (a figure that increases annually with cost-of-living—for 1974 it was $75,000; for 1979 it was $98,100) or 100 percent of the participating employe's average compensation for his highest three years. Therefore, contributions in excess of the 25 percent/$36,875 defined contribution limits are common in defined benefit plans.

In a defined benefit plan, the funds are pooled. They are amorphous. Indi-

*The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.*

## *Ophthalmology*
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# Wills Eye Hospital

**Topics:** Practical Anatomy and Physiology . . . Corneal Foreign Bodies, Abrasions, Chemical Burns . . . Contusive and Penetrating Injuries . . . Management of the Red Eye . . . Glaucoma for the Nonophthalmologist . . . Steroids and Ocular Disease . . . Ocular Complications in Systemic Drug Therapy . . . Recent Advances in Cataract Treatment

**Place:** *Wills Eye Hospital, Main Auditorium*
Ninth and Walnut Streets, Philadelphia, Pennsylvania

**Time:** *September 24, 1980 from 10 a.m. to 3 p.m.*
**Fee:** No charge
**CME Credits:** M.D. and D.O.
For further information and registration, contact: Department of Continuing Medical Education, Wills Eye Hospital, Ms. Lucia M. Manes, (215) 928-3258.


vidual investment direction is not an alternative.

The formula benefit set forth in a defined benefit plan is a commitment. An actuary is needed to track performance and compute the necessary corporate contribution. When investment performance is less than actuarial estimates and all other factors remain unchanged, future corporate contributions must increase to reach the defined benefit goal. When investment performance exceeds actuarial assumptions and all other factors remain the same, future corporate contributions must decrease to reach the defined benefit goal.

A defined benefit plan tends to be more costly than a defined contribution plan due to the increased complexities involved in the plan drafting and the acturial computations.

### 1.4 rule plans

For the physician whose income is substantially higher than his take-home needs and the defined contribution or defined benefit alternatives are not satisfying his desire and need to tax-shelter increased sums in a corporate retirement plan, a 1.4 rule approach is an option worth considering.

As described above, the maximum contribution on behalf of a participating employe under defined contribution plans is the lesser of 25 percent of compensation or $36,875. This maximum is 100 percent of what could be done, or 1.0 in such a plan.

The maximum benefit which can be funded under a defined benefit plan is the lesser of 100 percent or $110,625 (as described above). In other words that is 100 percent or 1.0 of what can be done with a defined benefit plan.

Some high-income professionals now exceed the above limits by taking advantage of a combination of two plans: defined benefit pension plan and money purchase pension plan, known as the 1.4 rule. A profit sharing plan cannot be used.

The limitation on such a defined benefit/money purchase pension plan combination is that the sum of the defined benefit plan fraction (the employe's defined benefit divided by the legally allowed maximum) and the defined contribution plan fraction (the contributions for the employe to the money purchase pension plan for that year divided by that maximum) for any participant in any year cannot exceed 1.4.

As an illustration consider a doctor whose salary from a corporation is $100,000. To meet the 1.4 rule, the defined benefit pension plan must provide a legally allowable maximum retirement benefit (1.0) and the money purchase pension plan must call for a 10 percent contribution (10 percent divided by 25 percent maximum equals 40 percent, or 0.4).

### Conclusion

The different basic types of corporate retirement plans offer a range of alternatives to the corporation. Each type should receive thoughtful consideration before being adopted. Any appropriate plan must be reviewed in greater depth to tackle its inherent intricacies and complexities.

# Pursuit of truth dispels crisis of trust

**Abraham J. Twerski, MD**

These remarks advised and challenged the new physicians at the 1980 commencement exercises of the University of Pittsburgh School of Medicine, May 27. Heraclitus said some 2,000 years ago that the only constant in the world is change. Change guarantees that at one point in time, the problems confronting any graduating class of physicians are unique. The author was commencement speaker.

Foremost among the epochal discoveries of the latter half of the 20th century is one which caught us all off guard. The unexpected revelation was that the medical doctor is, after all, a human being with feelings, emotions, needs, drives, and sensitivities. More than that, how and whether these are satisfied or frustrated makes a difference, not only in the physician's state of happiness or distress, not only in his family's well-being, but also in the quality of the physician's medical practice. Added to such personal and individual factors, there are those which affect medical practice as a whole, and as such affect the personality of the physician. In recent months, I have become more intimately concerned with problems affecting the personality of the physician, what can be done about them *after* they occur, and what can be done to *prevent* their occurrence.

Probably every graduating class of new physicians has been advised that the problems confronting them are new and unique, and this has generally been true. Heraclitus said it some 2,000 years ago—the only constant in the world is change. These ongoing changes have guaranteed that the challenges presenting at one point in time will be different from those of an earlier or later period.

Obviously, adaptation to change may correspond inversely to the intensity of change. When the changes are gradual, most physicians will adapt well. But when the changes are radical, those who can respond to major readjustments will survive and thrive, whereas those lacking in adaptability are apt to remain with obsolete approaches, with both their productivity and sense of personal achievement analagous to someone driving on an expressway in a horse-drawn buggy.

The recent changes in medicine are too many to be mentioned here. There have been major changes in diagnostic techniques, therapeutic methods, in theory and basic sciences, in direction of research, in economics and other social factors, and last but certainly not least, in the monstrous growth and impact of both governmental and non-governmental bureaucracies. I wish to touch on two factors which I consider to be of great importance.

Far from existing isolated and in pure culture, medicine exists and functions in an environment, and is affected by all the forces in the environment. Often these forces may be too subtle to notice until someone or something makes us aware of their existence.

The doctor-patient relationship is the foundation upon which successful medical treatment rests. Notwithstanding the biochemical action of antibiotics and cardiac glycosides, the most potent tool in the physician's therapeutic armamentarium remains the *patient's trust in the doctor.*

Without trust in the physician, the patient would not ingest or inject potent chemicals. Without trust in the physician, the patient would not allow himself to be rendered unconscious and have his abdomen opened, and in more recent years, his very heartbeat brought to a standstill. And it is often the trust in the physician which allays paralyzing anxiety and acts as a potent anodyne for severe pain.

The word, trust, is rapidly acquiring the status of a rare and endangered species. Trust seems threatened with virtual extinction.

If it is true, as some psychologists contend, that the feeling of trust is patterned after the trust of the child in the parent, one can appreciate the ero-

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*Dr. Twerski is medical director of Gateway Rehabilitation Center and clinical director of the psychiatry department at St. Francis General Hospital, Pittsburgh. He has written for* PENNSYLVANIA MEDICINE *on many topics including the bureaucracy, iatrogenic addiction, and the impaired physician.*

*'The medical doctor is, after all, a human being with feelings, needs, and drives.'*

sion of trust as a consequence of the culturally-evident diminished trust of the child in the parent. The recent change in Pennsylvania legislation which makes the 14-year-old independent of the parent and beyond the authority of the parent to obtain treatment for him is just one cultural reflection of the loss of confidence in the parent.

Much has happened to seriously undermine trust. Despite our knowledge of Machiavellian techniques, we nevertheless perceived the office of the Chief Executive of the United States with reverence, perhaps because we wished to believe in its integrity. But the watchful eyes of the media have uncovered duplicity among the highest officials of the country. Our generation witnessed a president leaving office in disgrace, not because of a petty burglary, but because he violated the trust of the country in lying to the people.

We may have had one last vestige of faith in humans that we had clung to desperately, perhaps because we still wished to believe in some type of transcendent integrity. We trusted that there were nine men of impeccable character in whose hands was shaped the foundation of our country. We trusted that their considerations and deliberations of the fundamentals of a democratic society emanated solely from pure principle. Now we have had that sweet dream shattered by a documentary which shows them to be fairly avid worshipers at the altar of expedience, replete with pettiness and opportunism.

Day after day, we are deluged with revelations which seem to justify the sick story of the father who played a game with his little son. He would stand the child high on a bookcase and have him jump into his waiting hands. One time, after many such playful sessions, the child jumped, and the father stepped back. The bruised child wailed pitifully, "Daddy, why did you do that?" and the father replied, "Son, it is my duty to prepare you for the real world. In this world, never trust anyone."

It would be a mistake to assume that this prevalent cynicism and malignant skepticism has been without effect on the patient-doctor relationship, particularly since those unsympathetic to medicine further incite distrust in medicine via the sensationalism which the mass media exploit. And indeed we also have suffered the consequences of the advance of sophisticated, scientifically technical medicine, which has displaced the archetype of the warm, fatherly family physician, sharing a cup of coffee with the family after examining and treating the patient in the home, becoming intimately familiar with every aspect of the family's life.

Today perhaps the scientific physician has the advantage of the culture and sensitivity of the microorganism. His medical ancestor had the more potent advantage of the culture and sensitivities of the patient. The loss of intimacy with the patient in his natural habitat and the pan-erosion of faith and trust in authority as a whole have seriously impacted upon the trust of the patient in the physician, greatly attenuating this wonderful therapeutic tool.

*'The most potent tool in the physician's therapeutic armamentarium is the patient's trust.'*

If anyone tampered with our digitalis, our antibiotics, or other life-saving drugs so as to reduce their effectiveness, we might become militant in protecting the potency of these substances. With the same vigor, we must combat this erosion of trust in the physician, for *that,* after all, is our supreme therapy.

We know that although the overwhelming majority of physicians are capable and dedicated to excellent patient care, there are those few whose practices are exploitative and dishonorable to the profession, and rarely even an incompetent physician. We can no longer allow the assurance of quality of care to be solely the responsibility of governmental licensing bureaus. These plod along at a snail's pace, encumbered by myriads of legalisms and technicalities.

We should obtain firm and unequivocal legislation to provide immunity for peer review performed in good faith. We should exercise this function vigorously so that the public we serve will have no reason to doubt that the practicing physician may be trusted without equivocation.

To regain the trust of our patients, we must pursue truth relentlessly. The physician must be sensitive to the feelings of the patient. At no time is there any justification for removing hope. Patients *have* survived illnesses which physicians believed were hopeless; however, the well-intentioned lie to protect a patient from the truth about his condition seldom can be justified in today's educated society. Patients know that chemotherapy and radiation are not used for benign conditions; any attempt to distort the truth will result in distrust of the physician.

As a fledgling resident, I ordered a placebo for a patient whose pain appeared to me not to be genuine, as though there were such a thing as spurious pain. The patient never received the placebo. It was against the

policy of the hospital's director who explained to me that giving a patient a nothing while telling him it is a something violates the patient's trust and cannot be condoned.

I wish to stress the need for reinstatement of the trust of the patient. No longer can we take it for granted. We now must strive to achieve it.

The nature of medical practice has witnessed another change. At least some, if not the greater part of the motivation to become a physician stems from the need to be of perceptible help to someone. There are other helping occupations, but the immediacy of the physician's helping the human body, restoring function, and relieving pain, renders the doctor's accomplishment unequalled in providing a sense of satisfaction and accomplishment.

How I used to gloat when I could resurrect a comatose patient in insulin shock with an intravenous dose of glucose, or return the breath of life to the anguished asthmatic by using epinepherine and aminophyllin. These types of gratifications are still ours to enjoy, but their relative frequency in the totality of medical practice has diminished. At least two factors are responsible for this reduction in personal gratification.

Knowing that I have done all that I possibly can for a patient may give me peace of conscience, but if that patient is still sick or suffering, I do not derive much emotional gratification. If a patient can achieve a degree of recovery measurable only in millimeters, or if maintaining the *status quo* and preventing deterioration is all I can do, I may know intellectually that I have done a good job, but the reward of observing recovery is not forthcoming. It is a frustrating feeling when we have reached a therapeutic plateau with a severely emphysematous or arthritic patient, and although we are doing everything possible, nevertheless we are consistently confronted with a chronically-dissatisfied and complaining patient.

We may be justly proud of having extended the life span, but we have not yet been blessed with solving the many problems that occur in advancing age. The wear and tear diseases, the connective tissue diseases, the diminished resistance to infections, all of these are more prevalent as the elderly population increases, and these present themselves to us in increasing numbers of chronic, and stubbornly resistant conditions.

*'Scientifically technical medicine has displaced the archetype of the warm, family physician.'*

Many people are alive and functioning better today because of the availability of cytotoxic and immunosuppressive agents. But these wonder drugs are not an unmixed blessing. At times we may find ourselves in the awkward position that although we have brought a life-threatening disease under control, the patient actually is complaining more as a result of some consequence of his treatment. Intellectually, he knows he is being helped, but the discomfort may overcome the fact and the net result is an unhappy patient. Needless to say, an unhappy patient does not make for a happy physician.

We must recognize that we are moving into an era which justifiably may be called the *era of chronicity*. As long as our triumphs are incomplete, we will have chronic, persistent diseases, which will not permit the physician to be the dramatic rescuer as often as he would like to be.

A second factor in the diminishing personal gratification applies to the specialist. Medical education has been quite effective. There are many journals and many courses available, and one might even have to admit that CME is not without redeeming factors. With the availability of medical tapes, my travel time in my car is no longer wasted. I frequently listen to tapes outside my own speciality.

The problem that this has created, is that many conditions previously referred to the specialist now are being treated by the primary therapist or by the physician of another specialty whom the patient may be seeing. Thus, I would not boast of my skills in dermatology, but with my knowledge and the potent dermatologicals available, when I refer a patient to a dermatologist because the problem is beyond me, the dermatologist will not get a patient with a simple skin problem.

A colleague recently remarked about the nature of patients under his care. For some reason, all the cases he was now seeing were either severe psychoneurotics, severely and chronically depressed people, or difficult-to-manage schizophrenics. He wondered if the nature of mental illness had changed, and why his practice had become so different from a few years ago.

The answer is simple. We have succeeded in educating the non-psychiatric physician in the use of antidepressants, anti-psychotic agents, and anxiolytic drugs. The patient who is being referred to the psychiatrist is no longer the uncomplicated depressive. That patient is being managed with the proper medications by whatever physician is treating him.

Today, the depressed patient who is referred to the psychiatrist probably

*'Ministering to suffering is a noble goal, but our ultimate purposes must transcend our occupation.'*

has had two or three unsuccessful trials with antidepressants, and if still depressed is apt to be a decompensated, severely characterological obsessive-compulsive whose psychiatric treatment is just as apt to bring about depression in the psychiatrist as a cure in the patient. The phenomenon of the distraught family bringing a dejected patient into the office, and the psychiatrist being able to bring about dramatic relief within two to three weeks, occurs less frequently today.

I suspect that this is as true of other specialties as it is of psychiatry. A urologist who receives a referral from me, can be sure that this is not a simple *E.coli* urinary tract infection, because this I treat myself. The urologist probably would have on his hands a pseudomonas, for which he may have to use potent antibiotics whose increased toxicity makes for a smaller margin of safety. He still may get a good result, but it is not going to be without sweat.

On top of all of this, the burgeoning, bungling, nagging, and nauseating bureaucracies can be relied on to annoy the hell out of us, and make us wish we were anything but physicians.

The focus must be on such distressing factors, because unless we are aware of what the sources of distress are, we cannot combat them or compensate for them. There are no simplistic solutions but I believe that we can take remedial action. Already I have discussed some measures that can help restore patient trust, and knowing what the problem is, we can look for yet other approaches.

As far as personal gratification is concerned, I would like to preface these remarks with a request that they not be misunderstood nor distorted. I believe we must recognize the fact that due to the above factors, our emotional gratification from our professional lives may not be as great as those of our forebearers.

We must enrich our lives from other sources, something we should have been doing all along. We may turn to those erstwhile strangers, namely, our spouses and children, and increase our emotional investment in them. The familiar phenomenon of the physician who is too preoccupied being a doctor to be a good spouse or parent is no longer tenable.

We will have to set new priorities, foremost of which should be our families. We will have to devote more time cultivating interests in the arts. We will have to repudiate the conflict between science and religion, and as individuals dedicated to the preservation of life, come into a closer relationship with the Author of life.

Ministering to human suffering is a noble goal, but we must think also in terms of ultimate goals, of purposes in life that transcend any and every occupation, and that give us cause to live and purposefulness even when age or infirmity restricts the practice of our profession.

These and other things will not only bring us additional sources of personal gratification, but will increase our wholesomeness as complete human beings. And so we return to the first item, the crisis of trust, for I believe that a greater fullness as a fellow human rather than only as a purveyor of scientific skills may greatly advance the cause of the trust of one human being in another. □


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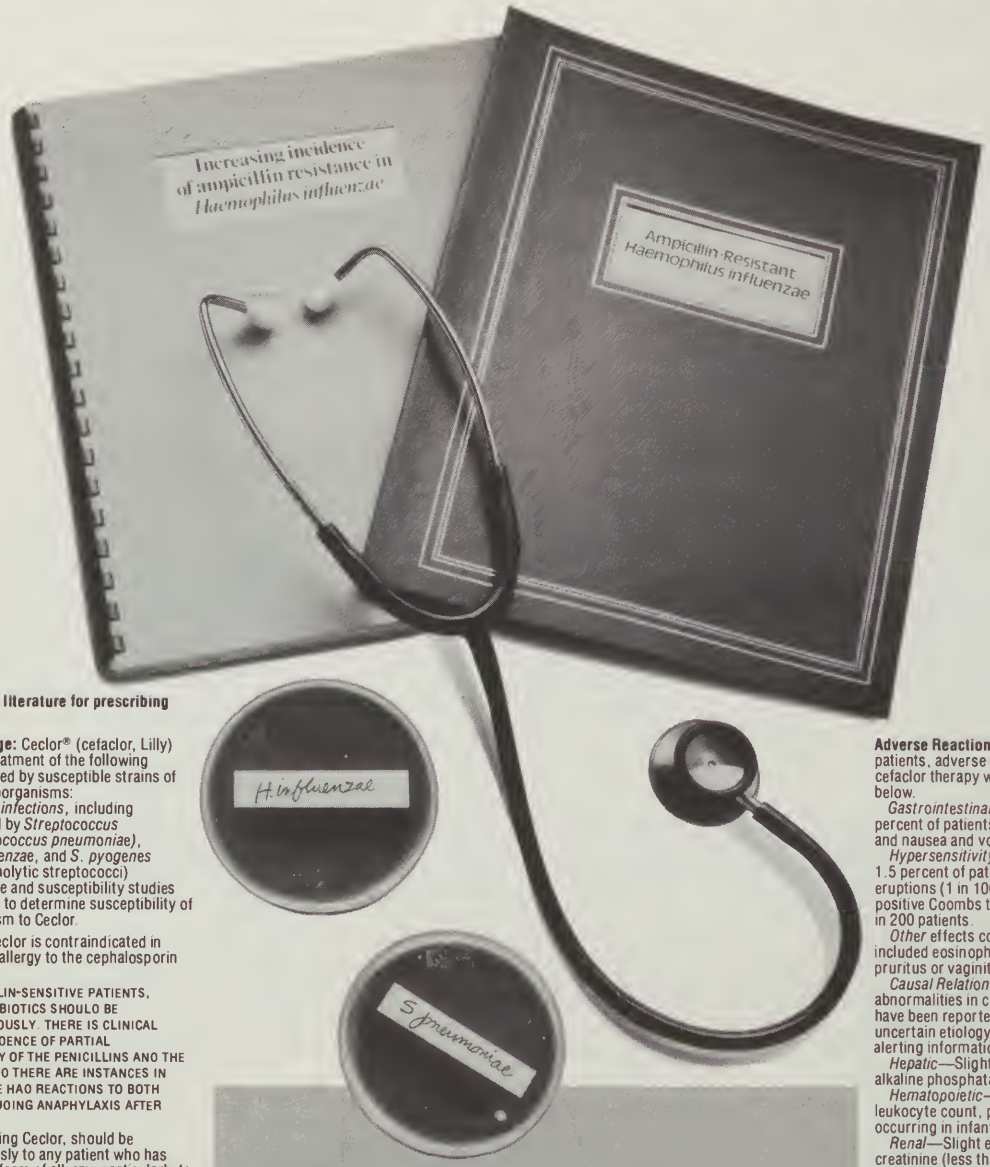
# An added complication... in the treatment of bacterial bronchitis*




**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage:** Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note:* Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.*

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# Modern therapy of pituitary tumors

Leonard F. Hirsh, MD

Diagnosis, evaluation, and treatment of pituitary tumors have changed radically in the last ten years. New sophisticated radiographic techniques allow earlier detection of small tumors. Hormonal assays and endocrine function tests may reveal tumors too small to be seen by any x-ray technique. The microsurgical transsphenoidal approach to the pituitary gland provides for removing an adenoma and preserving or restoring anterior pituitary lobe function.

Ten to fifteen percent of all brain tumors are pituitary tumors. The pituitary adenoma was recognized as an entity following Pierre Marie's description of acromegaly in 1886.[1] In 1926 Dott described the various histologic tumor types, recognizing the chromophobe adenoma associated with anterior pituitary insufficiency and the eosinophilic adenoma related to acromegaly and gigantism.[2]

Until Cushing's work the clinical significance of the basophilic adenoma was not recognized. Hyperthyroidism caused by a TSH-producing pituitary adenoma was described in 1955.[3] Some cases of the amenorrhea-galactorrhea syndrome were attributed to a prolactin-secreting adenoma by Forbes et al in 1954.[4]

These various tumor types have not consistently been associated with one of the three classical staining characteristics, *i.e.,* chromophobic, eosinophilic, or basophilic. The discovery of these types has necessitated a re-evaluation of pituitary tumors.

Most pituitary tumors (85 percent) used to be considered endocrinologically inactive and chromophobic on histologic staining. Now endocrine inactive tumors make up no more than 20 percent of all pituitary tumors. Most of the others secrete either growth hormone (33 percent) or prolactin (39 percent).[5]

Many of the tumors previously classified as chromophobic now can be shown on immunohistologic techniques to be associated with intracellular hormonal granules. Elevated serum prolactin levels may not cause any clinical disturbance, and thus many pituitary tumors secreting only prolactin will resemble clinically the classic chromophobe adenoma.

## Clinical presentations

Pituitary adenomas generally present with visual loss, headache, or sellar enlargement; and/or endocrine deficiency or oversecretion. Sudden onset of obtundation, meningismus, paresis of cranial nerves II, III, IV, or VI, or bloody spinal fluid signifying acute pituitary necrosis (apoplexy) rarely will be the presentations of a pituitary tumor.

Visual loss and endocrine deficiency are typical of large pituitary tumors which expand the sella and which compress the optic nerves and chiasm by suprasellar extension. Endocrine-inactive tumors or prolactin-secreting tumors not producing hormonal effects are the neoplasms which may grow to this large size before detection. These tumors classically are considered chromophobe adenomas. The visual deficit is generally a relative bitemporal hemianopsia with normal visual acuities; however, homonomous field cuts, binasal hemianopsias, decreased visual acuity, or optic atrophy can be seen.[6]

These large pituitary adenomas, which clinically are endocrinologically inactive, produce endocrine deficiency from pituitary gland compression. Diabetes insipidus from posterior pituitary insufficiency is rare.

Low serum growth hormone is the most consistent laboratory finding. Gonadotrophin deficiency indicated by amenorrhea or decreased libido is the most frequent clinical sign. Low gonadotrophins, low adrenocorticotrophin hormone, and finally low thyrotrophin are the next most common endocrine findings.[7] Pituitary reserve should be tested with metyropone.

Such tumors produce radiographic sellar enlargement, carotid artery displacement on angiography, and abnormal CT scans or pneumoencephalograms.

Endocrine-active pituitary adenomas, except for many prolactinomas, usually are discovered early while they are still small. The clinical picture of gigantism or acromegaly from excessive growth hormone, or of Cushing's syndrome from elevated pituitary adrenocorticotrophin hormone is not usually overlooked.

## Differential diagnosis

Other disease-simulating pituitary tumors also must be considered. Sellar enlargement from an arachnoid diverticulum extending into the sella, the empty sella syndrome, may simulate a pituitary tumor. Visual changes or endocrine deficiencies are rare.

Para- or intrasellar aneurysms may produce sellar enlargement, visual field deficits, and endocrine insufficiency. The correct clinical diagnosis may be suspected from the asymmetry of the visual fields. Angiography confirms this diagnosis.

Other tumors such as craniopharyngeomas or metastases may enlarge the sella. At times these may be indistinguishable from pituitary adenomas.

## Indications for treatment

*Endocrine inactive tumors:* Patients with truly inactive tumors (*i.e.,* not prolactinomas) and with no visual deficits may be followed closely. Progressive sellar enlargement by x-ray, the development of visual field deficits, or the progressive loss of endocrine function are all indications for treatment. Such classical "chromophobe adenomas" are best treated when small.

When the visual loss is less than a bitemporal hemianopsia and visual acuity is normal, standard radiation

*Dr. Hirsh is assistant professor in the neurosurgery department of Hahnemann Medical College and Hospital, Philadelphia and chief of the neurosurgical section at Crozer-Chester Medical Center, Chester.*

**DESCRIPTION:** Methyltestosterone is 17$\beta$-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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treatment and endocrine replacement is probably the best initial therapy for patients over 60 years of age.[13] When visual loss progresses during or following radiotherapy, surgery is needed.

In patients under 60 years of age, radical tumor removal by surgery will provide treatment and minimize the recurrence risk. Postoperative radiotherapy can be delayed until evidence of tumor recurrence occurs, as noted radiographically by position changes in the sellar clips placed at surgery. This approach may decrease the chance of late radiation brain damage by delaying or avoiding the need for radiotherapy.

Pituitary tumors secreting only prolactin are handled in a similar fashion unless the symptoms produced by the prolactin oversecretion are too troublesome. Severe galactorrhea may require earlier treatment to prevent visual deficits from occurring in these patients. Trans-sphenoidal radical sellar cleanout is the approach of choice.

Pituitary microadenomas secreting only prolactin are treated as endocrine active tumors.

*Endocrine active tumors:* Patients with endocrine active tumors are best treated by radical surgery. When the elevated hormone level returns to normal, the patients can be followed endocrinologically. Recurrence of elevated hormone levels will require further surgery or radiotherapy.

Amenorrhea-galactorrhea in women[8] or hypogonadism in men[9] now is associated with serum prolactin excess. Thyroid-stimulating-hormone-producing adenomas are very rare, most secondary to prolonged hypothyroidism,[10] but some occasionally associated with hyperthyroidism.[11] Only a few cases of gonadotrophin-producing adenomas have been reported.[12]

When discovered early these tumors are small and have not produced visual deficits, general hormonal deficiency, or gross sellar enlargement. Polytomography (not linear tomography) of the sella in the lateral and coronal planes is required to detect small depressions of the sella floor produced by secreting microadenomas. CT scanning, angiography, or pneumoencephalography are usually normal.

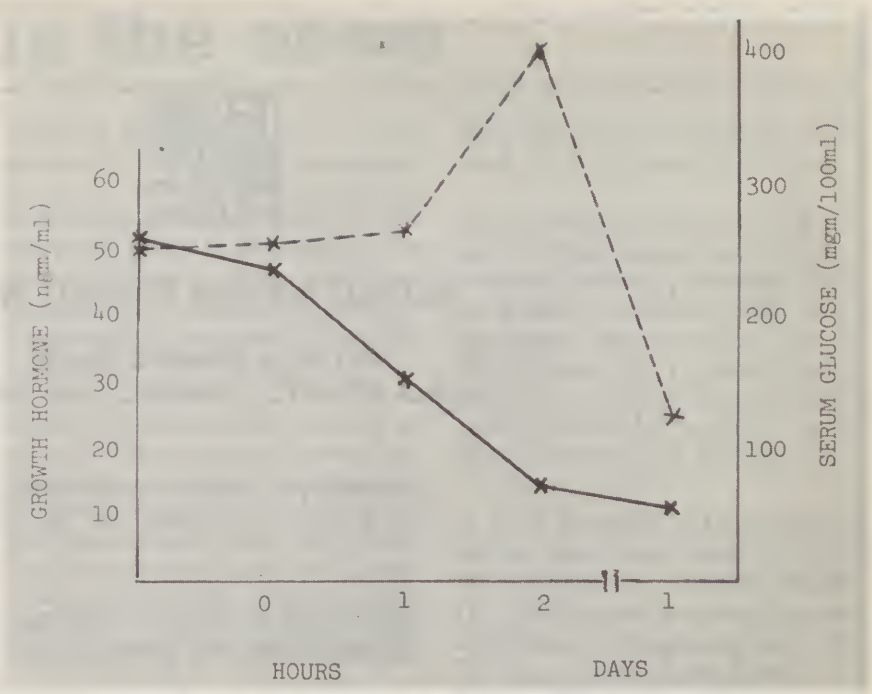


*Figure 1.* **Postoperative rapid decrease in serum growth hormone level (solid line) following trans-sphenoidal pituitary surgery. Time 0 is actual tumor removal.**

**Clinical evaluation**

Patients with visual loss or clinical hypopituitarism without any hormonal excess most likely harbor endocrine-inactive or prolactin-secreting tumors. These tumors are usually chromophobic on classical staining. Other than involvement of the visual apparatus, the neurological exam is normal. Endocrine evaluation as noted above will reveal hypopituitarism with or without elevated serum prolactin. Radiologic studies reveal an enlarged sella. CT scanning with injection may reveal the tumor.

Bilateral carotid angiography is essential prior to treatment to exclude an intrasellar aneurysm. Fractional pneumoencephalography ("mini PEG" with 15-25 cc of air only) is recommended intraoperatively or prior to surgery when the trans-sphenoidal approach is planned in order to evaluate the extent of suprasellar expansion. A pneumoencephalogram is not necessary for a transfrontal.

Patients who present with symptoms of hormonal oversecretion often harbor small adenomas; however, many growth hormone or prolactin-secreting tumors are diffuse. Such "macro-adenomas" can produce visual loss, general endocrine deficiencies, or sellar enlargement.

Microadenomas do not produce neurologic or visual abnormalities. Endocrine evaluation often reveals minimal endocrine deficiencies and confirms the elevated hormone level. Sellar polytomography may not reveal any signs of a tumor. CT scanning is usually normal. Carotid angiography is warranted pre-operatively to exclude coincidental vascular anomalies prior to the trans-sphenoidal approach, even though it is clear that intrasellar aneurysms cannot produce hormonal excess. Pneumoencephalography is less beneficial.

Many of these patients will have pituitary microadenomas. Trans-sphenoidal surgery is the initial treatment of choice. Often this allows selective removal of the adenoma, normalization of hormone levels,and preservation of the other normal pituitary functions (Figure 1).[14–17]

With the availability of trans-sphenoidal microsurgery and an awareness of these microadenomas, initial treatment of endocrine active tumors by conventional radiotherapy or proton beam irradiation does not seem warranted, given the chances of late brain radionecrosis.

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*Pituitary apoplexy:* The sudden onset of obtundation, visual loss, or cranial nerve palsies from pituitary necrosis is best treated by trans-sphenoidal removal of the necrotic tumor.

### Surgical techniques

The classical subfrontal removal of pituitary tumors still is indicated whenever the diagnosis is doubtful or when gross suprasellar tumor extension would preclude adequate tumor removal by the trans-spenoidal route. When the sphenoid sinus is poorly pneumatized, complicating the trans-sphenoidal approach, the subfrontal approach may be preferable.

The trans-sphenoidal approach is indicated for most endocrine active tumors, especially microadenomas.[18] The surgical morbidity is low in experienced hands. No surgical scar is visible, and the postoperative course is usually smooth. Pituitary tumors extending predominantly into the sphenoid sinus are best treated by the trans-sphenoidal route.

### Conclusion

Modern radiographic techniques, endocrine evaluation, and micro-neurosurgery allow a more complete and rational treatment of pituitary adenomas. Using these advancements permits the possibility of preserving normal hormonal function.

### REFERENCES

1. **Marie, P.:** Sur deux cas d'acromégalie. Hypertrophie singuliere non congénitale des extrémités superieurs, inferieurs, et céphalique. *Rev de Med 6:*297-333, 1886.
2. **Dott, N.M., Bailey, P., Cushing, H.:** A consideration of the hypophysial adenomata. *Brit J Surg 13:*314-366, 1925.
3. **Albeaux-Fernet, M., Guiot, J., Braun, S., et al:** Exophthalmic oedémateuse maligne traité par hypophysectomie. Presence d'une. hyperplasie cyanophile à cellules delta sur les coupes. *Bull Mém Soc Med Hos Paris 71:*220-229, 1955.
4. **Forbes, A.P., Henneman, P.H., Griswold, G.C., et al:** Syndrome characterized by galactorrhea, amenorrhea and low urinary FSH: Comparison with acromegaly and normal lactation. *J Clin Endocr 14:*265-271, 1954.
5. **Landolt, A.M.:** Progress in pituitary adenoma biology - results of research and clinical applications. *Advances and Technical Standards in Neurosurgery,* Krayenbühl (ed.), Springer-Verlag, New York, Vol. 5, 1978.
6. **Henderson, W.R.:** The pituitary adenomata. *Brit J Surg 26:*811, 1939.
7. **Jenkins, J.S.:** *Pituitary Tumours,* Butterworths, London, 1973.
8. **Kleinberg, D.L., Noel, G.L., Frantz, A.G.:** Galactorrhea: A study of 235 cases, including 48 with pituitary tumors. *New Eng J Med 296:* 589-600, 1977.
9. **Carter, J.N., Tyson, J.G., et al:** Prolactin secreting tumors and hypogonadism in 22 men. *New Eng J Med 299:* 847-852, 1978.
10. **Leong, A.S.Y., Chawla, J.C., Teh, E.C.:** Pituitary thyrotropic tumour secondary to long-standing primary hypothyroidism. *Path Europ 11:*49-55, 1976.
11. **Mornex, R., Tomasi, M., Curé, M., et al:** Hyperthyroidie asociée à un hypopituitarisme au cours de l'évolution d'une tumeur hypophysaire sécrétant TSH. *Ann Endocr (Paris) 33:*390-396, 1972.
12. **Cunningham, G.R., Huckins, C.:** A FSH and prolactin-secreting pituitary tumor: Pituitary dynamics and testicular histology. *J Clin Endocrinol Metab 44:*248-253, 1977.
13. **Svien, H.J., Colby, M.Y.:** *Treatment for Chromophobe Adenoma,* Charles C. Thomas, Springfield, Ill., 1967.
14. **McLanaham, C.S., Christy, J.H., Tindall, G.T.:** Anterior pituitary function before and after trans-sphenoidal microsurgical section of pituitary tumors. *Neurosurg 3:*142-145, 1978.
15. **Garcia-Uria, J., del Pozo, J.M., Bravo, G.:** Functional treatment of acromegaly by trans-sphenoidal microsurgery. *J Neurosurg 49:*36-40, 1978.
16. **Tindall, G.T., McLanaham, C.S., Christy, J.H.:** Trans-sphenoidal microsurgery for pituitary tumors associated with hyperprolactinemia. *J Neurosurg 48:*849-860, 1978.
17. **Salassa, R.M., Laws, E.R., Carpenter, P.C., Northautt, R.C.:** Trans-sphenoidal removal of pituitary microadenoma in Cushing's Disease. *Mayo Clin Proc 53:* 24-28, 1978.
18. **Wilson, C.B., Dempsey, L.C.:** Trans-sphenoidal microsurgical removal of 250 pituitary adenomas. *J Neurosurg 48:*13-22, 1978.

# physicians in the news

The Medical College of Pennsylvania recently awarded **Donald R. Cooper, MD,** the Christian R. and Mary F. Lindback award for distinguished clinical teaching. Dr. Cooper is senior department chairman in surgery at MCP. From 1972 through 1979, he served as first district trustee representing Philadelphia County on the PMS board of trustees.

**David B. Soll, MD,** professor and chairman of the ophthalmology department at Hahnemann Medical College and Hospital co-chaired an international conference on eye surgery held recently in Jerusalem. The conference established a long-term relationship between the eye departments of Hahnemann and Israel's Hadassah University Hospital.

**Sol Sherry, MD,** professor and chairman of the medicine department at Temple University School of Medicine, recently received its first Faculty Research Award. Dr. Sherry also received an honorary Doctor of Science degree at the University's commencement exercises, May 29. His research on thrombosis, emobolism, and the interruption of blood flow has contributed to advances in thrombolytic therapy.

**Gerhard Werner, MD,** has been appointed F.S. Cheever Distinguished Professor at the University of Pittsburgh School of Medicine. Dr. Werner is professor and chairman of the pharmacology department and also served as vice president for professional affairs and dean of the medical school.

**John J. Dennehy, MD,** recently received the Silver Beaver award for distinguished service to boyhood presented by the Columbia-Montour Boy Scout Council. Chief of the infectious disease department at Geisinger Medical Center, Dr. Dennehy visits the scouts at Camp Lavigne during the summer to give them their physicals.

**David W. Wilder, MD,** chairman of the radiology department at Conemaugh Valley Memorial Hospital, recently was elected to a three-year term on the board of directors of the Pennsylvania Radiological Society.

**Victor F. Greco, MD,** recently was elected governor of Rotary District 741 which includes 41 clubs in Northeastern and Central Pennsylvania. Dr. Greco, a general and thoracic surgeon, is chairman of the Cancer Detection Centers in the Wilkes-Barre and Hazleton areas and chairman of the board of White Haven State School.

*International Surgery,* the official journal of the International College of Surgeons recently published a paper by **Milton J. Freiwald, MD,** of the MacSander Memorial Eye Clinic of Pennsylvania. Dr. Freiwald's article, "Melanoma of the iris: Conservative or radical therapy?" appears in the March-April issue of the journal.

**J. Paul Proudfit, MD,** recently received recognition from the First Presbyterian Church of Washington. Dr. Proudfit has practiced internal medicine in Washington since 1949. He is a member of the Board of Directors of Washington County Medical Society and has served as chairman of its Grievance Committee since 1974.

**Jay Nicholson, MD,** recently was elected president of the York-Adams Chapter of the American Heart Association. Dr. Nicholson is a four-year staff cardiologist at York Hospital.

Pennsylvania State University recently honored **Kenneth Weston, MD,** by naming him a Distinguished Alumnus. Dr. Weston, captain of the

**Sidney O. Krasnoff, MD,** recently received the State of Israel's Maimonides Award presented at the Israel Bonds Dinner in his honor at the Warwick Hotel, Philadelphia. Attending the presentation were, from left to right, **H. Arnold Muller, MD,** state secretary of health, Dr. Krasnoff, **George Manstein, MD,** tribute chairman and leader of Bonds' Medical Division, and Raymond Alexander, president of Albert Einstein Medical Center. Dr. Krasnoff is president of Philadelphia County Medical Society and chairman of the medical staff and senior attending physician at Albert Einstein Medical Center.

Nittany Lions football team and member of the track team in the 1920s, is emeritus chief of orthopedics at Allentown Hospital. PSU recognized Dr. Weston for his pioneering efforts in restoring joints after athletic injuries.

**C. Everett Koop, MD,** surgeon-in-chief at Children's Hospital of Philadelphia, recently received the Legion of Honor from the government of France for his contributions to the development of pediatric surgery. Dr. Koop, 63, specializes in correcting life-threatening birth defects. In 1974, he directed the 23-member team that successfully separated Clara and Altagracia Rodriguez, 13-month-old Siamese twins.

The Academy of Santa Chiara recently admitted **Giulio J. D'Angio, MD,** for his contributions to the study of cancer research and treatment, particularly for children. Dr. D'Angio is director of Children's Hospital of Philadelphia's Cancer Research Center and professor of pediatrics and professor of radiology at the University of Pennsylvania School of Medicine.

Governor Thornburgh and Secretary of Public Welfare Helen O'Bannon chose **Alan E. Kohrt, MD,** as a delegate to the East Coast regional meeting of the White House Conference on Families held June 6-8 in Baltimore. Dr. Kohrt is a member of the Health Systems Agency board of directors and pediatric consultant to the Wayne County Children and Youth Services.

**E. Fannie Freedman, MD,** former woman of the year in medicine, has been named the first woman ship's surgeon of the USS Olympia, Adm. George Dewey's flagship. The ship is moored in Philadelphia and is under the command of Capt. Caspar J. Knight, chairman of the board of directors of the Olympia Association and Historic Ships in the U.S. Navy.

**Ruth W. Wilson, MD,** a practicing physician in Beaver County for 56 years, recently was elected to the American Lung Association's Hall of Fame. Dr. Wilson earned the honor through her efforts in combating and halting the spread of tuberculosis and other lung diseases.

The National Aeronautics and Space Administration has named **James Philip Bagian, MD,** an astronaut candidate in its space shuttle program. Dr. Bagian, a resident in anesthesiology at the University of Pennsylvania Hospital, was selected as a missions specialist. He is one of 19 selected candidates from a group of 2,880 applications.

Port physician **George E. Burden, MD,** recently received honors in recognition of his 45 years of service to the Ports of Philadelphia. Dr. Burden received the Philadelphia Maritime Exchange's Award of Merit for rendering care to thousands of merchant seamen. He is a 40-year member of the AMA.

**Robert G. Little, MD,** recently was elected president of the Dauphin County Unit of the American Cancer Society. Dr. Little also will serve as the unit's chief delegate to the American Cancer Society's annual meeting.

**Paul C. Gaffney, MD,** recently received honors from the Medical Alumni Association of the University of Pittsburgh School of Medicine. Dr. Gaffney, medical director of Children's Hospital in Pittsburgh, received the 1980 Hench Award.

**Milton Alter, MD,** recently was elected to serve a four-year term on the Board of Professional Advisors of the National Epilepsy Foundation. Dr. Alter is professor and chairman of neurology at Temple University Health Sciences Center, and currently is developing an epilepsy treatment unit at Temple University Hospital.

Lafayette College recently conferred the honorary degree of Doctor of Laws on **Marshall R. Metzgar, MD.** Dr. Metzgar has been a practicing physician in the Stroudsburg area since 1924.


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Harvey L. Waxman, MD, Internal Medicine, 314 S. 24th St., Philadelphia 19103

**BLAIR COUNTY:**
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**CUMBERLAND COUNTY:**
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**DAUPHIN COUNTY:**
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James C. Pierce, MD, General Surgery, Geisinger Med. Ctr., Danville 17821

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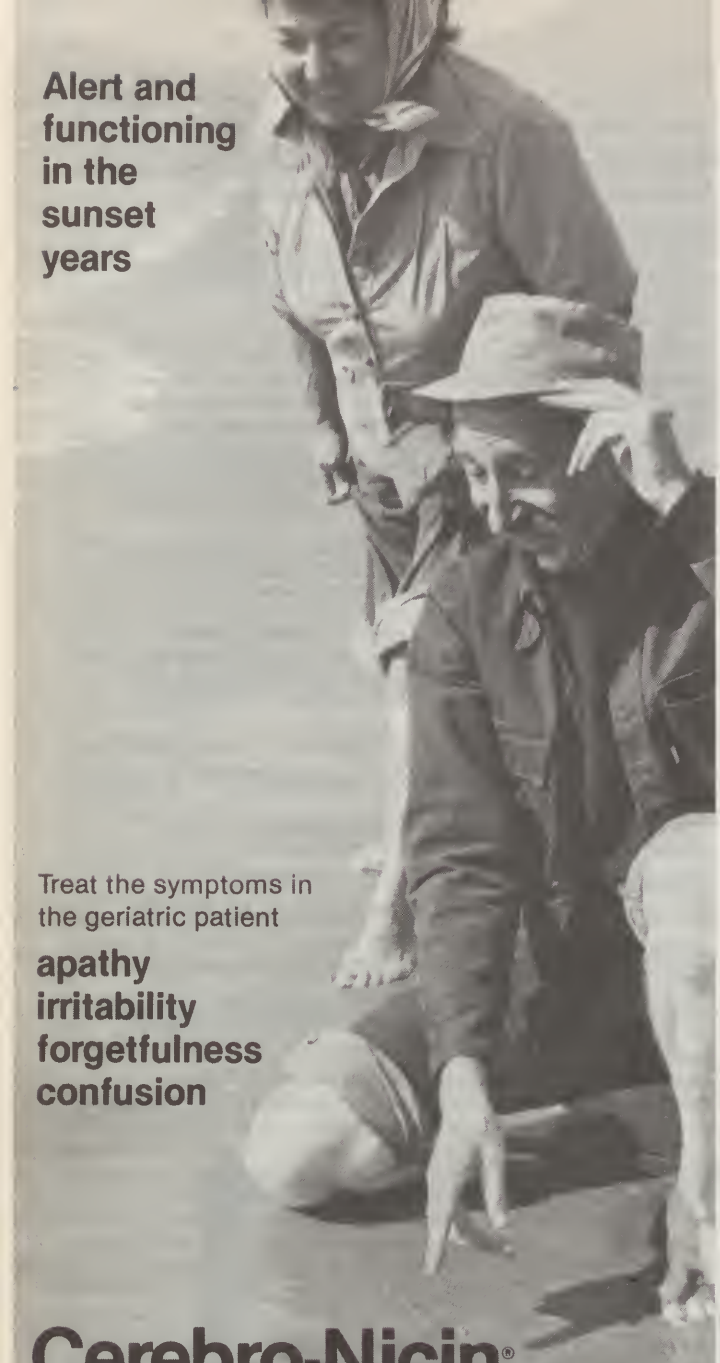

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# obituaries

• *Indicates PMS membership at time of death*

• **Fred Smellie Badman,** Harrisburg; Jefferson Medical College, 1939; age 66, died May 23, 1980. Dr. Badman had been a general practitioner in Harrisburg for 32 years.

• **Jacob Clifford Fair,** Dubois; University of Pittsburgh School of Medicine, 1931; age 75, died April 23, 1980.

• **Willis G. Frick,** Norristown; Jefferson Medical College, 1933; age 72, died May 23, 1980. Dr. Frick, member of the surgical staff of Montgomery Hospital, had been chief of staff at the hospital and a member of Montgomery Surgical Associates.

• **Thomas J. Madigan,** Pittsburgh; University of Pittsburgh School of Medicine, 1935; age 71, died June 15, 1980.

• **Robert E. Shoemaker,** Allentown; University of Pennsylvania School of Medicine, 1934; age 70, died June 16, 1980. Dr. Shoemaker practiced ophthalmology in Allentown for 34 years and was a past president of the Pennsylvania Academy of Ophthalmology and Otolaryngology. He was chief of ophthalmology emeritus at Allentown Hospital.

• **James W. Stirling,** Scottsdale, Arizona; University of Pittsburgh School of Medicine, 1932; age 75, died May, 1980.

• **James Theodore Valone,** Warren; University of Buffalo School of Medicine, 1927; age 77, died April 24, 1980.

• **James G. M. Weyand,** Kennebunkport, Maine; University of Pennsylvania School of Medicine, 1934; age 70, died May 14, 1980. Dr. Weyand practiced surgery in Beaver County from 1946 until 1973 and was former chief of surgery at Rochester General Hospital.

**Jonathan K. Henderson,** Philipsburg; University of Pennsylvania School of Medicine, 1923; age 83, died June 12, 1980. Dr. Henderson had been on staff at Philipsburg State Hospital and had served as a surgeon for the Pennsylvania and New York Central railroads.

**Elvin O. Onley,** Philadelphia; Howard University School of Medicine, Washington, D.C., 1962; age 50, died June 8, 1980. Dr. Onley was associated with the West Philadelphia Community Mental Health Consortium and was past director of the Institute for Urban Youth, Center for Urban Affairs at Morgan State College, Baltimore, Maryland.

**Raymond E. Seidel,** Philadelphia; Hahnemann Medical College, 1935; age 71, died May 29, 1980. Dr. Seidel had been a general practitioner in South Philadelphia for more than 40 years. He was a past president of the Pan-American Medical Association.

**Louis E. Silcox,** Punta Gorda, Florida; Yale University School of Medicine, New Haven, Conn., 1935; age 69, died June 1, 1980. Dr. Silcox was a former chief of staff at Lankenau Hospital and was a past president of the Pennsylvania Academy of Ophthalmology, the Philadelphia Laryngological Society and the Main Line branch of the Montgomery County Medical Society.

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12:45 p.m. - Shotgun Start
6:00 p.m. - Cocktails (cash bar) hors d'oeuvres
6:45 p.m. - Dinner

**Entry deadline: September 3, 1980**
**Limited to 120 golfers**
**No refund after September 3, 1980**

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## Entry Form

Name _____ ____ cart ____ caddy

Address _____

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**Please verify your handicap on day of Tournament**

Other members of foursome:

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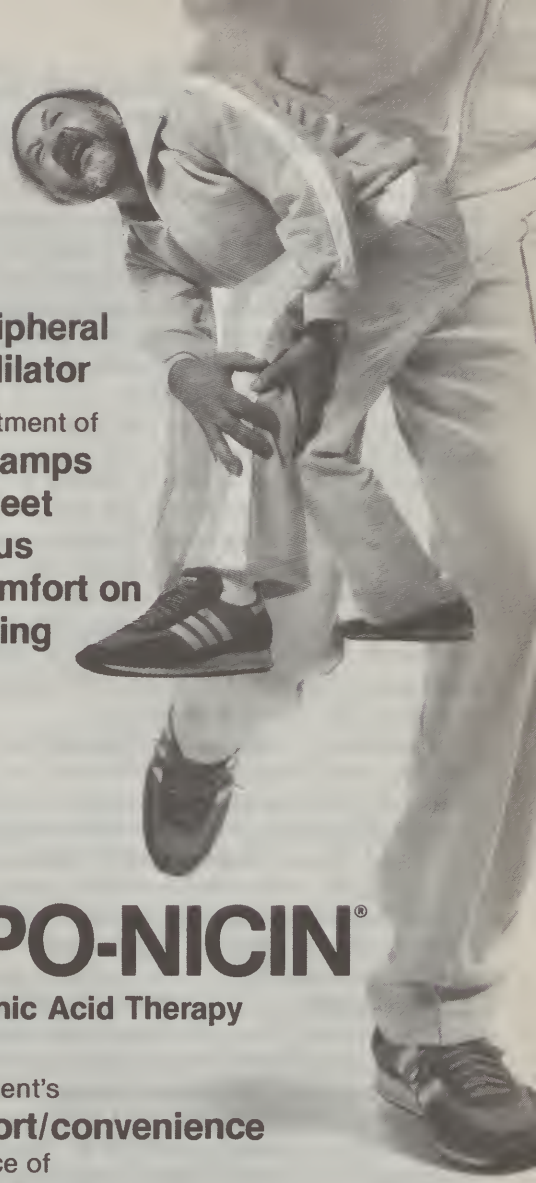

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# Official Call 1980 Annual Meeting
# Pennsylvania Medical Society House of Delegates

The 1980 annual meeting of the House of Delegates of the Pennsylvania Medical Society will be called to order at the Philadelphia Fairmont Hotel, Philadelphia, Pennsylvania, on Friday, October 31, 1980, at 9:30 a.m. The second session of the House of Delegates is scheduled for Saturday, November 1, 1980, at 1:00 p.m. The third and concluding session of the House of Delegates will be held Sunday, November 2, 1980, at 9:30 a.m.

**Elections**

In accordance with Article X, Section 3 of the Constitution, Chapter IV, Section 2 of the Bylaws, and Standing Rule Number 1 of the House of Delegates (revised October 23, 1972) of the Pennsylvania Medical Society, the following nominations and/or elections will be in order at the second session, Saturday afternoon, November 1, 1980.

General officers to be elected are a vice president, a secretary, a speaker of the House of Delegates, and a vice speaker of the House of Delegates.

In accordance with Article VIII, Section 3 of the Constitution and Standing Rule Number 1 of the House of Delegates, elections will be in order for a trustee and councilor for the Third Councilor District to serve three (3) years to succeed Richard L. Huber, MD, Lackawanna County, who is eligible for re-election; and a trustee and councilor for the Ninth Councilor District to serve three (3) years to succeed Carol N. Maurer, MD, Venango County, who is eligible for re-election.

In accordance with Chapter XIV, Section 2(e) of the Bylaws, elections for six (6) delegates and six (6) alternates to the American Medical Association are in order. The term is for two (2) years beginning January 1, 1981. Delegates whose terms expire December 31, 1980 are:

1. R. William Alexander, MD (Berks County)
2. James B. Donaldson, MD (Philadelphia County)
3. Raymond C. Grandon, MD (Dauphin County)
4. William J. Kelly, MD (Allegheny County)
5. Michael P. Levis, MD (Allegheny County)
6. William Y. Rial, MD (Delaware County)

The Committee to Nomiate Delegates and Atlernates to the AMA makes the following nominations for delegates for two (2) years commencing January 1, 1981:

1. R. William Alexander, MD (Berks County)
2. James B. Donaldson, MD (Philadelphia County)
3. Raymond C. Grandon, MD (Dauphin County)
4. William J. Kelly, MD (Allegheny County)
5. Michael P. Levis, MD (Allegheny County)
6. William Y. Rial, MD (Delaware County)

Alternate delegates whose terms expire December 31, 1980 are:

1. Donald C. Brown, MD (Westmoreland County)
2. Betty L. Cottle, MD (Blair County)
3. Joseph N. Demko, MD (Lackawanna County)
4. Charles A. Heisterkamp, III, MD (Lancaster County)
5. John L. Kelly, MD (Delaware County)
6. Irving Williams, MD (Union County)

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for alternate delegates for two (2) two-year terms commencing January 1, 1981:

1. Donald C. Brown, MD (Westmoreland County)
2. Harold J. Byron, MD (Montgomery County)
3. Betty L. Cottle, MD (Blair County)
4. Joseph N. Demko, MD (Lackawanna County)
5. Norman L. Ekberg, MD (Montour County)
6. Charles A. Heisterkamp, III, MD (Lancaster County)
7. James J. Houser, MD (Venango County)
8. John L. Kelly, MD (Delaware County)
9. David L. Miller, MD (Clarion County)
10. Jonathan E. Rhoads, Jr., MD (Philadelphia County)
11. Irving Williams, MD (Union County)

Also to be elected will be one member to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. The term of Samuel S. Faris, MD, Montgomery County, expires; he is eligible.

In accordance with Article IX, Section 5 of the Constitution, the Board of Trustees nominates the following members for a vacancy on the Judicial Council. For the office now held by Samuel F. Cohen, MD, Montgomery County, the Board nominates Gertrude Blumenschein, MD, Fayette County; Samuel F. Cohen, MD, Montgomery County; and James A. Collins, Jr., MD, Montour County.

Elections will be held for a district censor from each component medical society to serve for one (1) year following the close of the 1980 House of Delegates meeting as required by Chapter IV, Section 4 of the Bylaws. The component county medical societies submitted the following nominations for district censor:

Adams, Edward J. Baranski; Allegheny, William D. Stewart; Armstrong, Frank H. McNutt; Beaver, John G. Hallisey; Bedford, _____; Berks, Brian A. Wummer; Blair, John W. Stoker; Bradford, Arthur B. King; Bucks, Stanley F. Peters; Butler, Robert C. McCorry; Cambria, William E. Palmer, Jr.; Carbon, _____; Centre, H. Thompson Dale; Chester, Lewis P. Soraruf; Clarion, Charles C. Huston; Clearfield, _____; Clinton, _____; Columbia, Philip M. Irey, Jr.; Crawford, David D. Kirkpatrick, Jr.; Cumberland, Hans S. Roe; Dauphin, Robert B. Edmiston; Delaware, Raymond Krain; Elk-Cameron, John P. Delich; Erie, Robert L. Loeb; Fayette, Florencio P. Cardenas; Franklin, Albert W. Freeman; Greene, Stanley E. Falor; Huntingdon, _____; Indiana, _____; Jefferson, Nicholas F. Lorenzo; Lackawanna, Eugene G. Stec; Lancaster, William G. Ridgway; Lawrence, _____; Lebanon, John D. Walmer; Lehigh, William F. Boucher; Luzerne, Robert M. Kerr; Lycoming, Franklin G. Wade; McKean, Bruno P. Sicher; Mercer, Ira W. Flamberg; Mifflin-Juniata, Daniel K. Creighton, Jr.; Monroe, Richard P. Kennedy; Montgomery, Rudolph K. Glocker; Montour, William O. Curry; Northampton, Walter J. Filipek; Northumberland, Nicholas Spock; Perry, Frank A. Belmont; Philadelphia, _____; Potter, _____; Schuylkill, Arthur N. DiNicola; Somerset, _____; Susquehanna, Paul B. Kerr; Tioga, William P. Reich; Union, John H. Persing; Venango, Harry Kanhofer; Warren, Harold J. Reinhard; Washington, William H. Kittrell; Wayne-Pike, _____; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, Donald R. Gross.

# Proposed Amendments Constitution and Bylaws

Printed below is the text of amendments to the current Constitution and Bylaws and amendments to the proposed revision. Subject One is a proposed revision to amend the current Constitution and Bylaws in their entirety. Due to its length, this subject has been published in three installments. The first installment appeared in the June issue and the second installment appeared in the July issue of PENNSYLVANIA MEDICINE.

In this Official Call, Subjects Two and Three are amendments to this revision. If the House adopts the revision, Subject One, then these subjects shall be considered in order.

If Subject One, the proposed revision, is rejected, then Subjects Two, and Three shall not be considered. If this is the case, then Subjects Four Five, Six, Seven, and Eight shall be considered in order.

For this Official Call, in Subject One all the material is being added. Subjects Two through Eight of this Official Call, material in italics is being added and material in brackets is being deleted. The Secretary's Note at the end of each subject indicates the vote required and the origin of the proposal.

**SUBJECT ONE: Proposed revision to amend the Constitution and Bylaws in their entirety**

**Pennsylvania Medical Society Bylaws**

## CHAPTER XVI
## COMMITTEES, ADMINISTRATIVE COUNCILS, AND COMMISSIONS

**Section 1 — Appointment of Members, Vacancies, and Qualification** — All appointments of chairmen, vice chairmen, and members of committees, administrative councils, and commissions, the tenure and qualification of members and the filling of vacancies shall be as prescribed in these bylaws.

a. *Appointments of Chairmen, Vice Chairmen, and Members of Committees, Administrative Councils, and Commissions* — All such appointments shall be made by the President Elect at least 90 days prior to the next annual meeting of the House of Delegates, or by the Vice President if the President Elect shall be incapacitated or unable to perform the duties of his office or if a vacancy occurs in the office of President Elect before all appointments are made. In making appointments to commissions, the President Elect may consult with the members of the related administrative council. Appointments of the chairmen, vice chairmen, and members of administrative councils shall be subject to confirmation by the Board of Trustees.

b. *Appointment of Members and Chairmen of Special Committees* — Unless otherwise ordered by the House of Delegates, the President shall appoint the chairmen and members of special committees and shall determine the number of members of each.

c. *Terms of Chairmen, Vice Chairmen, and Members of Committees, Administrative Councils, and Commissions* — The period of time between the conclusion of one annual meeting of the House of Delegates and the conclusion of the next annual meeting shall be considered the term of office, unless otherwise provided for in these bylaws.

No member of an administrative council, committee, or commission shall serve more than six consecutive terms.

**Source and Analysis**

## CHAPTER XVI
## COMMITTEES, ADMINISTRATIVE COUNCILS, AND COMMISSIONS

**Section 1 — Appointment of Members, Vacancies, and Qualifications** — Chapter XIV, Section 1, pages 29-30 of the current Bylaws contains in subsections a-e all the provisions governing appointments, qualifications, and filling vacancies.

This new section repeats those provisions, using headings for the subsections to add clarity and stylistic consistency.

a. *Appointments of Chairmen, Vice Chairmen, and Members of Committees, Administrative Councils, and Commissions* — This new subsection repeats the President Elect's appointment authority; however, the Vice President is the designated authority to make appointments if the President Elect cannot.

b. *Appointment of Members and Chairmen of Special Committees* — This new subsection repeats the provision that the President make such appointments unless ordered otherwise by the House of Delegates.

c. *Terms of Chairmen, Vice Chairmen, and Members of Committees, Administrative Councils, and Commissions* — This new subsection repeats the provision with added clarity to the terms beginning at the conclusion of the annual meeting which is consistent with all preceding provisions.

For the purposes of this subsection, a member appointed to fill a term or unexpired term of less than one-half the regular term of that appointment shall not be deemed to have served a term.

d. *Qualification for Membership on Committees, Administrative Councils, and Commissions* — All members of this Society, other than affiliate, honorary, and special student members, shall be eligible to serve as members of committees, administrative councils, and commissions except:

1. No member of the Judicial Council shall be eligible for appointment to (a) any administrative council or commission, or (b) any committee, membership of which is prohibited by these bylaws.

2. The President, the President Elect, the Vice President, and members of the Board of Trustees shall not be appointed members of any standing committee, administrative council, or commission unless required by these bylaws.

3. A member may serve concurrently only as (a) a member of one administrative council and one commission under that council, or (b) a member of one council or one commission and standing committee, or (c) an appointed member of not more than two standing committees.

e. *Vacancies* — All vacancies shall be filled in the following manner:

1. Vacancies among elected members of standing committees shall be filled by the Board of Trustees until the next annual meeting of the House of Delegates when successors shall be regularly elected.

2. Vacancies on standing committees, special committees, and commissions originally appointed by the President Elect shall be filled by the President, with the advice, in the case of appointments to commissions, of the members of the related administrative council.

3. Vacancies on standing committees and special committees originally appointed by an individual or body other than the President Elect shall be filled by the individual or body originally appointing them.

4. Vacancies among the members or in the office of chairman or vice chairman of any administrative council shall be filled by the President. All such appointments shall be subject to confirmation by the Board of Trustees.

d. *Qualifications for Membership on Committees, Administrative Councils, and Commissions* — This new subsection repeats all the qualifications and restrictions for the abovementioned memberships.

e. *Vacancies* — This new subsection repeats the provisions for filling vacancies in the various committees, administrative councils, and commissions.

**Section 2 — Standing Committees** — This Society shall have the following standing committees:

Advisory Committee to the Pennsylvania Medical Society Auxiliary
Committee on Bylaws
Committee on Medical Benevolence
Committee on Aid to Education
Committee to Nominate Delegates and Alternates to the American Medical Association
Advisory Committee on Professionalism

Standing committees shall submit annually a written report to the House of Delegates to be delivered to the office of the Executive Vice President at least 60 days prior to the convening of the annual meeting of the House of Delegates.

a. *Advisory Committee to the Pennsylvania Medical Society Auxiliary* — The Advisory Committee to the Pennsylvania Medical Society Auxiliary shall consist of five mem-

**Section 2 — Standing Committees** — Chapter XIV, Section 2, pages 30-32 of the current Bylaws lists the standing committees (subsections a-f) of this Society and states that they must file annual reports to the House of Delegates with the executive vice president by July 1. Each committee is listed separately by subsection and its composition, duties, etc., detailed within.

This new section repeats all those provisions in the same format slightly reworded due to editing. The July 1 deadline for filing annual reports has been changed to "at least 60 days prior to an annual meeting of the House of Delegates" to accommodate the flexible scheduling of House meetings.

a. *Advisory Committee to the Pennsylvania Medical Society Auxiliary* — This new subsection repeats the description of the advisory committee slightly reworded.

bers appointed by the President Elect. It shall act in an advisory capacity whenever called upon by the Pennsylvania Medical Society Auxiliary.

b. *Committee on Bylaws* — The Committee on Bylaws shall consist of (1) five voting members of the House of Delegates appointed by the Speaker of the House of Delegates who shall also designate the chairman, and (2) the Speaker and Vice Speaker of the House of Delegates, the Secretary, legal counsel, and the Executive Vice President as ex-officio members without the right to vote. Three members of this committee shall be appointed on odd-numbered years for two-year terms, and two members of this committee shall be appointed on even-numbered years for two-year terms. No member shall serve more than two consecutive two-year terms.

The term of a member of this committee shall begin with the opening session of the annual meeting of the House of Delegates following his appointment and shall conclude immediately prior to the third annual meeting thereafter.

This committee shall constantly study the bylaws and recommend revisions and modifications necessitated by changing times, methods, or conditions. This committee shall serve as the Reference Committee of the House of Delegates as provided in these bylaws.

c. *Committee on Medical Benevolence* — The Committee on Medical Benevolence shall consist of the Secretary of the Society who shall be secretary of the committee, and three members selected annually by the Board of Trustees, at least one of whom shall be a member thereof. The committee shall select its own chairman and shall perform the duties prescribed in these bylaws.

d. *Committee on Aid to Education* — The Committee on Aid to Education shall consist of three members selected annually by the Board of Trustees, at least one of whom shall be a member thereof. This committee shall select its own chairman, shall perform the functions prescribed in these bylaws, shall encourage all members to contribute to loan and scholarship funds of the Educational and Scientific Trust of the Pennsylvania Medical Society and of the component societies, and upon request from the American Medical Association shall stimulate member contributions and assistance to the educational and research programs and funds of said association.

e. *Committee to Nominate Delegates and Alternates to the American Medical Association* — The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of five members elected by the House of Delegates to serve a term of three years. This committee shall select its own chairman annually immediately upon adjournment of the annual meeting of the House of Delegates.

It shall be the duty of this committee to submit to the House of Delegates a list of nominees for Delegates and Alternates to the House of Delegates of the American Medical Association who are qualified under the requirements of the American Medical Association to hold such office. In the discharge of this responsibility, the committee shall formally request recommendations of nominees from each component society. It shall further be required to publish its list of nominees in the Official Call to the forthcoming House of Delegates meeting wherein the election is to be

b. *Committee on Bylaws* - Since the Society will have one set of bylaws, the committee's name has been changed accordingly. This new subsection adds that the Speaker designates the chairman, which, in fact, is the current practice. The sentence that all proposals for amendments to the bylaws be submitted to this committee in advance is deleted. The sentence was inconsistent with the amendment process which permits members to submit amendments directly to the House of Delegates under certain conditions.

c. *Committee on Medical Benevolence* - This new subsection repeats the description of the committee.

d. *Committee on Aid to Education* - This new subsection repeats the description of the committee.

e. *Committee to Nominate Delegates and Alternates to the American Medical Association* - This new subsection repeats the description of the committee.

held. Nothing in this section shall be construed as to prohibit nominations from the floor. Service on the Committee to Nominate Delegates and Alternates to the American Medical Association is limited to two terms.

f. *Advisory Committee on Professionalism* — The Advisory Committee on Professionalism shall consist of seven members, one of whom shall be the Secretary of this Society, who shall be chairman. The six remaining members shall be appointed by the President Elect for terms of two years or less, so that annually only three vacancies need to be filled.

Members of this committee, other than the chairman, may not concurrently serve on the Judicial Council, a grievance committee, or as a district censor.

The duties of this committee are:

1. To serve as consultants to component society grievance committees and/or boards of censors when requested;
2. To discuss, investigate, and/or refer to the appropriate body of PMS matters brought to its attention by individuals, government agencies, or peer review bodies;
3. To refer to the appropriate licensing body those cases which it deems appropriate in accordance with the Principles of Medical Ethics; and
4. To continually review disciplinary processes for improvement.

Activities of this committee shall not conflict with or supersede provisions for disciplinary proceedings and appeals.

f. *Advisory Committee on Professionalism* — This new subsection repeats the description of the committee, slightly edited.

**Section 3 — Special Committees** — This Society may have such special committees as the House of Delegates determines.

a. *Reporting* — Each such committee shall submit a written report at the annual meeting of the House of Delegates next following its creation, and at each annual meeting thereafter until the committee is discharged. The report shall be delivered to the office of the Executive Vice President 60 days prior to the convening of the annual meeting of the House of Delegates.

**Section 3 — Special Committees** — Chapter XIV, Section 3, page 32 of the current Bylaws provides for the House of Delegates to establish special committees and requires that such committees report annually to the House of Delegates. These provisions are repeated in this new section with the July 1 deadline for filing annual reports replaced by the "at least 60 days" phrase.

**Section 4 — Administrative Councils** — This Society shall have administrative councils as deemed necessary to carry out the business of the Society. The final determination thereof shall be the responsibility of the Board of Trustees, subject to review by the House of Delegates.

The administrative councils shall conduct all of the activities and business of the Society except as otherwise provided in these bylaws. Each administrative council shall have general supervision over the commissions assigned to it.

a. *Composition* — The Board of Trustees shall determine the number of members of each administrative council. Such members shall be appointed by the President Elect and shall be qualified in accordance with these bylaws. A trustee appointed by the chairman of the Board of Trustees shall be a member of each administrative council, ex-officio without the right to vote. Each administrative council shall have a chairman and a vice chairman appointed by the President Elect.

b. *Budget and Other Reporting* — Each administrative council shall report directly to the Board of Trustees and to

**Section 4 — Administrative Councils** — Chapter XIV, Section 4, pages 32 and 33 of the current Bylaws describes the duties, composition, reporting, etc., of the administrative councils of this Society. This new section repeats those provisions with appropriate subsection headings added for clarity.

the House of Delegates annually, at least 60 days prior to the convening of the annual meeting. After receiving recommendations from the members of each council, the council chairman shall submit to the Board of Trustees a budget covering the council's work.

c. *Consultants* — Any council or commission may be augmented by not more than eight consultants, appointed by the council with the approval of the President. Such consultants shall be recognized authorities in their fields. Their appointments shall terminate at the annual meeting of the House of Delegates.

**Section 5 — Commissions** — Each council shall recommend the number and size of commissions it deems necessary. The final determination thereof shall be the responsibility of the Board of Trustees. Members of commissions shall be appointed and shall be qualified as provided in these bylaws. The chairman of each commission shall be a member of the council to which the commission is assigned.

**Section 5 — Commissions** — Chapter XIV, Section 5, page 33 of the current Bylaws provides for the number and size of commissions to be determined by the Board of Trustees and that the chairman of each commission be chosen from the council to which the commission is assigned. This new section repeats those provisions.

## CHAPTER XVII
## PRINCIPLES OF MEDICAL ETHICS

**Section 1 — General Scope** — The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

## CHAPTER XVII
## PRINCIPLES OF MEDICAL ETHICS

**Section 1 — General Scope** — Article XII, page 11 of the current Constitution requires members to adhere to the Principles of Medical Ethics of the American Medical Association. This new section repeats that provision edited.

## CHAPTER XVIII
## THE JUDICIAL COUNCIL

**Section 1 — Duties** — The judicial power of this Society shall be vested in the Judicial Council. Its decisions shall be final, subject to the right of appeal to the Judicial Council of the American Medical Association as provided in the Constitution and Bylaws of the American Medical Association and in the bylaws of this Society.

**Section 2 — Composition** — The Judicial Council shall consist of five members, qualified as provided in these bylaws. The members shall serve terms of three years, and shall be elected by the House of Delegates on nomination by the Board of Trustees or from the floor of the House.

At least 30 days prior to each annual meeting of the House of Delegates, the Board of Trustees shall nominate at least three qualified persons for each vacancy on the Judicial Council. The Board shall publish their names to the membership of this Society in the journal of this Society or by some other appropriate means. Failure of the Board to nominate any, or a sufficient number of, candidates or to publish their names shall not invalidate any election which the House of Delegates validly conducts.

The Judicial Council annually shall select, at its first meeting, a chairman and a vice chairman from among its members. The Secretary of this Society shall serve as secretary of and alternate member of the Council. The Secretary shall become a voting member of the Judicial Council when any regular member is unable to attend a meeting. Three members, including the alternate member, shall constitute a quorum.

## CHAPTER XVIII
## THE JUDICIAL COUNCIL

**Section 1 — Duties** — Article IX, Section 1, page 7 of the current Constitution describes the judicial power of this Society being vested in the Judicial Council with a right to appeal clause. This new section repeats that provision.

**Section 2 — Composition** — Article IX, Section 5, page 8 of the current Constitution describes the composition of the Judicial Council, how nominated and elected, and that the Council elects its own chairman and vice chairman. This new section repeats all those provisions.

**Section 3 — Qualifications of Members** — To be eligible for election to the Judicial Council a member of this Society:

a. must have served as (i) a president of this Society; or (ii) a member of the Board of Trustees for at least one full term; or (iii) a member of the House of Delegates or an appropriately seated alternate delegate personally registered and in attendance at least at one session of the House of Delegates per year for a minimum of five years; and

b. must not be a member of a component society, a member of which (i) is serving as a member of the Judicial Council and whose term will continue during any portion of the period for which the new member is to be elected, or (ii) has previously been elected to the Judicial Council at the same election.

No person shall be eligible to serve for more than three consecutive terms, but a member elected to serve an unexpired term shall not have served a term unless he has served more than one year. For this purpose, a year shall be the period between annual meetings of the House of Delegates.

**Section 3 — Qualification of Members** — Article IX, Section 6, page 8 of the current Constitution describes who may qualify to be nominated and elected to a Judicial Council position. This new section repeats those qualifications.

**Section 4 — Vacancies** — In the event of a vacancy on the Judicial Council between annual meetings of the House of Delegates, the Board of Trustees shall have the power to fill such vacancy by majority vote. Such appointed members shall serve until the next annual meeting of the House of Delegates.

**Section 4 — Vacancies** — Article IX, Section 7, page 9 of the current Constitution provides for the Board of Trustees to fill vacancies on the Judicial Council occurring between annual meetings of the House of Delegates. This new section repeats that provision.

**Section 5 — Quorum** — Three members of the Judicial Council shall constitute a quorum.

**Section 5 — Quorum** — Article IX, Section 8, page 9 of the current Constitution stipulates that three members of the Judicial Council constitutes a quorum. This new section repeats that requirement.

**Section 6 — Original Jurisdiction** — The Council shall have original jurisdiction in:

a. all questions involving membership in this Society or in a component society; or the rights and standing of members, whether in relation to other members, to component societies, to the State Society, or to the public, except as such questions arise in connection with disciplinary proceedings instituted by any component society or any board of censors or other similar group;

b. all controversies falling under the bylaws of this Society, or the Principles of Medical Ethics, including cases in which a member has been convicted of an offense or committed to an institution under a charge for which his medical license may be revoked, but excluding all other controversies involving the discipline of a member; and

c. controversies between two or more component societies or their members.

**Section 6 — Original Jurisdiction** — Article IX, Section 2, page 7 of the current Constitution explains when the Judicial Council has original jurisdiction. This new section repeats those conditions for original jurisdiction.

**Section 7 — Appellate Jurisdiction** — The Council shall have appellate jurisdiction to review the proceedings in disciplinary cases before any intermediate appellate body created under the bylaws hereof, or before any final tribunal of any component society in appeals taken pursuant to the provisions of the bylaws of this Society.

**Section 7 — Appellate Jurisdiction** — Article IX, Section 3, page 7 of the current Constitution provides for the Judicial Council's appellate jurisdiction. This new section repeats that provision.

**Section 8 — General Jurisdiction** — The Council shall have jurisdiction on all questions of medical ethics, and on the interpretation of the bylaws, resolutions, and rules of

**Section 8 — General Jurisdiction** — Article IX, Section 4, pages 7 and 8 of the current Constitution describes the general jurisdiction of the Judicial Council in medical

this Society.

The Council may determine that any provision, or the manner of adoption of any provision, of the bylaws or any resolution, rule, or other action of the House of Delegates is contrary to law or to the bylaws or to the duly adopted procedures, resolutions, or rules of this Society, and is therefore invalid in whole or in part. In such event, the Council shall forthwith report its action to the Executive Vice President of this Society, or in the absence thereof, to any officer of this Society. The Executive Vice President, or such officer, shall promptly call a meeting of the Board of Trustees, to convene within 21 days from the date of such action by the Council. The purpose of the meeting shall be to effect the intent of the House of Delegates by some other means, if such is possible, within the powers granted to the Board of Trustees under the bylaws.

In acting on matters within its jurisdiction, the Judicial Council shall not make any determinations based on its own policies, nor shall any of its decisions constitute legislation for this Society. Nothing contained in this section, however, shall prohibit the Council from interpreting the policies established by the House of Delegates or the Board of Trustees, if the statement of such policy is ambiguous.

The Council also shall have power, at its discretion, to investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public. It may make such recommendations to the House of Delegates or the component societies as it deems necessary.

## CHAPTER XIX
## DISCIPLINARY BODIES/ PROCEEDINGS AND APPEALS

**Section 1 — Scope of Disciplinary Proceedings** — No disciplinary proceedings shall be conducted by any body of this Society, except (a) a component society, (b) original disciplinary proceedings by the Judicial Council as provided in Section 3 of this chapter, (c) appeals to district boards of censors as provided in Section 4 of this chapter, and (d) appeals to the Judicial Council as provided in Section 5 of this chapter.

a. *Components Boards of Censors* — Each component society shall establish a county board of censors to be responsible for disciplinary proceedings involving members of the component society. Each county board of censors shall file a report on disciplinary activities annually with the Secretary of this Society.

b. *District Boards of Censors* — Each component society shall elect a district censor who may not be a member of a grievance committee or the component society's board of censors or the Judicial Council of this Society.

1. The district censor shall serve on the district board of censors comprising the district censors from each of the component societies in the district.

2. The Trustee from the district shall serve as chairman of the district board of censors without the right to vote.

3. In districts with fewer than three component societies, there shall be added to the district's board of censors the district censors of the adjoining component societies.

ethics, interpretations of bylaws provisions, rules and resolutions of this Society, and how it should report its findings if a conflict exists. The section also states the broad restriction that determinations of the Judicial Council do not constitute legislation and further provides for the Judicial Council to investigate general professional conditions, etc.

This new section repeats all the elements of the Judicial Council's general jurisdiction.

## CHAPTER XIX
## DISCIPLINARY BODIES/PROCEEDINGS AND APPEALS

**Section 1 — Scope of Disciplinary Proceedings** — Chapter XIII, Section 1, page 26 of the current Bylaws describes what bodies may conduct what type of disciplinary proceedings, requires component societies to have boards of censors, and delineates the secretary's obligations to channel signed communications containing charges against a member of this Society.

This new section repeats those provisions but includes subheadings for clarity and inserts the District Boards of Censors as subsection b. Chapter XII, Section 1, page 25 of the current Bylaws provides for district boards of censors and designates how each is composed. Section 2 of Chapter XII, page 26 of the current Bylaws, describes the district boards of censors appellate jurisdiction. These provisions also are repeated in this new subsection. As previously explained, each component society elects its own district censors.

4. The district boards of censors shall have jurisdiction in all cases of appeals from the decisions of component societies as provided in these bylaws.

c. *Communications Received by the Secretary* — All written and signed communications, received by the Secretary of this Society, containing charges against a member which could require disciplinary proceedings, shall be forwarded by the Secretary to the appropriate grievance committee. If the Secretary shall not have received reasonable assurances within 45 days after receipt of the communication by the grievance committee that the grievance committee has considered the charges, the Secretary may refer a copy of the communication to the county board of censors.

If the Secretary shall not have received reasonable assurances within 45 days after receipt of a copy of the communication by the county board of censors that the county board of censors has considered the charges, the Secretary may refer a copy of the communication to the district board of censors, which may initiate original disciplinary proceedings.

**Section 2 — General Rules** — Except as the context otherwise requires, the following general rules shall apply to all disciplinary proceedings before the Judicial Council, whether original proceedings or appeals, and the district boards of censors:

a. *Charges* — The charge or charges upon which the proceeding is based must be in writing and in sufficient detail to enable the member to defend properly against the charges.

b. *Notification* — A copy of the written charge or charges against a member or a copy of the appeal and brief, must be sent by registered mail to all interested parties, at their addresses as they appear on the records of this Society, at least 30 days prior to the date of any hearing. The date and the place of such hearing shall be set forth therein.

c. *Prompt Attention* — The Judicial Council and the district boards of censors shall act as promptly as possible in holding hearings.

d. *Hearing Protocol* — The member must be accorded a fair and impartial hearing. At the hearing he may be represented by an attorney; he may be confronted by the witnesses and documentary evidence, if any; he may have an opportunity to cross-examine the witnesses; and he may present any matter pertinent to his defense.

The Judicial Council and the district boards of censors shall not be bound by the rules of evidence used in courts. They may receive oral or written evidence judged by them to present the relevant facts best and most fairly. Except in extraordinary circumstances, the Judicial Council shall not receive new or additional evidence in appeal cases.

e. *Decisions* — The Judicial Council and the district boards of censors shall render their decisions with reasonable promptness. Decisions of the Judicial Council, whether in original proceedings or on appeals, shall be concurred in by a majority of the members of the Judicial Council present at the hearing, which shall be not less than three. Decisions of the district boards of censors shall be concurred in by a majority of the members of the district board of censors present at the hearing.

In the event of a tie vote in original proceedings before

**Section 2 — General Rules** — Chapter XIII, Section 2, pages 26 and 27 of the current Bylaws describes the general rules which apply to the disciplinary proceedings of the Judicial Council or a district board of censors divided into subsections a-e. This new section repeats the general rules and subsections, adding only headings for clarity to subsections a-e.

the Judicial Council, the charges against the member shall be dismissed. In the event of a tie vote in appeals, either by a district board of censors or by the Judicial Council, the decision appealed from shall be sustained.

All decisions of the Judicial Council and the district boards of censors shall be in writing. Copies thereof shall be given promptly to the interested parties. Copies of decisions of the district boards of censors shall be given promptly to the chairman of the Judicial Council.

**Section 3 — Original Disciplinary Cases Before the Judicial Council**

a. *Charges* — In all cases of original disciplinary proceedings against a member of this Society before the Judicial Council as provided in these bylaws, the charge or charges upon which the proceeding is based must be brought by a majority vote of either the Board of Trustees or the district board of censors that has jurisdiction over the member's component society.

b. *Decision* — If the decision of the Judicial Council finds the member guilty of any of the charges, the decision shall state the penalty, if any, to be imposed. The penalty may be censure, suspension, or expulsion from membership in this Society, regardless of any recommendation or suggestion for penalty made in the charges.

**Section 3 — Original Disciplinary Cases Before the Judicial Council** — Chapter XIII, Section 3, page 27 of the current Bylaws describes who may bring charges for original disciplinary proceedings and the responsibility of the Judicial Council in rendering decisions. This new section repeats the provisions in subsections with new headings for clarity.

**Section 4 — Appeals to District Boards of Censors** — Any member of a component society who has been censured, suspended, or expelled thereby, and any physician who has been refused membership by a component society, or any component society aggrieved by the decision of another component society's board of censors shall have the right of appeal to the district board of censors for that district.

To have the right of appeal:

a. written notice of the appeal must be given to the Trustee of the district within 60 days after the censure, suspension, expulsion, or notice of rejection of an application for membership (the failure of a component society to accept or to reject an application for membership within six months after the filing thereof shall automatically be deemed a rejection at the end of said six months period); and

b. a brief outlining the basis of such appeal must be presented to said Trustee within 90 days after either of the events heretofore mentioned.

**Section 4 — Appeals to District Boards of Censors** — Chapter XIII, Section 4, page 27 of the current Bylaws describes the appeal procedure to district boards of censors. This new section repeats the provision.

**Section 5 — Appeals to the Judicial Council** — Any member of any component society or any component society aggrieved by a decision of a district board of censors may appeal from such decision. Such member or society must give written notice of said appeal to the Judicial Council within 60 days after the date of the decision of the district board of censors and must submit a brief outlining the basis of such appeal to the Judicial Council, within 90 days after the decision of the district board of censors. The action of the Judicial Council in cases of appeals shall be limited, except in extraordinary circumstances, to a review of the record of the proceedings before the district board of censors.

**Section 5 — Appeals to the Judicial Council** — Chapter XIII, Section 5, page 27 of the current Bylaws provides for appeal from the district boards of censors to the Judicial Council. This new section repeats that appeal provision.

**Section 6 — Appeals to the Judicial Council of the**

**Section 6 — Appeals to the Judicial Council of the AMA —**

**American Medical Association** — Any component society or any member of the American Medical Association aggrieved by a decision of the Judicial Council of this Society may appeal such decision to the Judicial Council of the American Medical Association in accordance with the bylaws and rules thereof. If such right of appeal is not exercised, then the effective date of decisions as prescribed in these bylaws shall prevail.

Chapter XIII, Section 6, page 28 of the current Bylaws provides for further appeal from the PMS Judicial Council to the AMA Judicial Council. This new section repeats that appeal provision slightly reworded.

**Section 7 — Effective Date of Decisions of Component Societies, District Boards of Censors, and the Judicial Council** — No action of any component society censuring, suspending, or expelling a member and no action of any district board of censors affirming any such action shall become effective so long as the member has any right of appeal according to these bylaws, or during the pendency of any such appeal.

All decisions of the Judicial Council, whether in original proceedings or on appeals, shall become final upon the issuance thereof, except that any such decision involving a member of the American Medical Association shall not become effective until 30 days after the decision of the Judicial Council, and, if the member or the component society, if any, has given written notice to the Judicial Council of the American Medical Association, during said 30-day period, of his or its intention to appeal to that body, and furnishes a copy of such notice to the Judicial Council of this Society, and, in the case of a member, to the secretary of his component society, until the expiration of the appeal period and the final disposition of the appeal by the Judicial Council of the American Medical Association.

**Section 7 — Effective Date of Decisions of Component Societies, District Boards of Censors, and the Judicial Council** — Chapter XIII, Section 7, page 28 of the current Bylaws describes the effective date of decisions of these disciplinary bodies. This new section repeats those provisions.

**Section 8 — Notification of Expulsion** — Written notification of all final decisions expelling a member for disciplinary reasons shall be given to the appropriate licensing body and the appropriate hospital medical staff.

**Section 8 — Notification of Expulsion** — Chapter XIII, Section 8, page 28 of the current Bylaws requires written notification of expulsion of a member to be sent to the State Board of Medical Education and Licensure and the appropriate hospital medical staff. This new section repeats that requirement slightly reworded.

**Section 9 — Automatic Suspension** — Any member of this society convicted by a court of competent jurisdiction of committing a felony or any crime involving moral turpitude, shall be automatically suspended for an indefinite period. It shall be the duty of the Secretary promptly to inform the appropriate county board of censors of any such conviction of any member of this Society; however, any member of the Society having any such information should promptly report the same to the county board of censors.

The county board of censors shall make due inquiry. If it finds that such member has, in fact, been so convicted, the county board of censors shall order a certified copy of the conviction from the court, and upon receipt thereof shall file said copy with the member's records. The county board of censors shall thereupon notify the member that he will stand suspended from membership for an indefinite period, beginning 90 days following his conviction by the court, or ten days following the notice, if such notice is issued more than 90 days after the conviction, unless prior to the effective date of the suspension the member certifies to the county board of censors that he has filed an appeal from the conviction.

**Section 9 — Automatic Suspension** — Chapter XIII, Section 9, page 28 of the current Bylaws mandates automatic suspension of membership of a member convicted of certain crimes and the procedure for invoking said suspension. This new section repeats these provisions.

If the member so convicted has so appealed, the suspension from membership shall be stayed until such time as the appeal has been finally disposed of by a court of last resort. Such suspension shall be completely nullified in the event the court reverses the member's conviction.

**Section 10 — Other Suspensions of Membership** — A member shall be suspended from membership in this Society:

a. on December 31 of any year if he is an active or associate member who has failed to qualify for the American Medical Association's Physician's Recognition Award provided the office of the Executive Vice President has given such member 60 days notice prior to December 31 that such suspension will be invoked unless such member shall submit sufficient supplemental records to fulfill such award requirements by December 31, and such suspension shall remain in force until such member submits sufficient supplemental records to fulfill the award requirement;

b. upon suspension of his membership in his component society; and

c. upon the effective date, as provided in these bylaws, of an order to that effect issued by the Judicial Council of this Society or a district board of censors.

**Section 10 — Other Suspensions of Membership** — Chapter I, Section 6, page 14 of the current Bylaws describes the various suspensions other than automatic, the rights of members while suspended, and restoration of membership under CME.

This new section repeats the various suspensions, but the rights of members are separated for clarity into its own section and the sentence on restoring membership privileges is included in Section 13 of this chapter.

**Section 11 — Rights of Members During Suspension** — The suspended member shall not be entitled to exercise any of the rights and privileges of membership during the period of suspension, but shall continue to be obligated for the payment of annual assessments without any reduction whatsoever.

**Section 11 — Rights of Members During Suspension** — This new section repeats the provision from Chapter I, Section 6, page 14 of the current Bylaws as previously mentioned.

**Section 12 — Termination of Membership** — The membership of a member of this Society shall terminate:

a. in the case of active or associate members suspended who have not completed the continuing medical education requirement for the American Medical Association's Physician's Recognition Award by the end of a one-year period of suspension;

b. upon (i) termination of his membership in his component society for any reason whatsoever, or (ii) failure to pay a delinquent assessment within 30 days after notice of such delinquency as provided in these bylaws, or (iii) three months after ceasing to be eligible for the class of membership in which he is a member as specified in these bylaws, unless at such time an application or certification for another class of membership for which the member will become immediately eligible is pending in the office of the Executive Vice President of this Society; and

c. upon the effective date, as provided in these bylaws of an order to that effect issued by the Judicial Council of this Society or a district board of censors.

**Section 12 — Termination of Membership** — Chapter I, Section 7, page 14 of the current Bylaws describes the various terminations of membership. This new section repeats those termination criteria.

**Section 13 — Reinstatement of Membership After Termination** — Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year and reinstatement by his component society. No such member under any circumstances shall be considered to be

**Section 13 — Reinstatement of Membership after Termination** — Chapter I, Section 8, page 14 of the current Bylaws describes the criteria for reinstatement after termination. This new section repeats those criteria.

a member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of these bylaws.

Any active dues-paying or associate member whose membership has been terminated for failing to meet the requirements for the American Medical Association's Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met all the requirements for such award for a current period and that at least one-third of the required hours were earned during the previous 12 months.

Any person whose membership has been terminated for failure to pay a special assessment shall be reinstated upon payment of the delinquent special assessment.

**Section 14 — Reinstatement of Membership After Automatic Suspension** — Any member indefinitely suspended from membership pursuant to the provisions of Section 9 of this chapter may be reinstated to full membership after a period of six months from the effective date of the suspension.

Applications for reinstatement may be submitted not earlier than four months after the effective date of the suspension. Applications shall be in writing and shall set forth the reasons why the member believes he is entitled to reinstatement. They shall be filed with the county board of censors.

The county board of censors, after due inquiry, shall meet to consider the application. The suspended member shall be reinstated upon a majority vote of the members of the county board of censors present and voting at the meeting, provided that there is a quorum of at least four members.

**Section 15 — Expulsion of Unqualified Witness** — Any member of this Society who testifies as an expert witness without meeting the qualifications set forth in this section shall be subject to expulsion after a due process hearing as provided for in these bylaws. An expert witness must have basic educational and professional knowledge as a general foundation for his testimony, and in addition, have current personal experience and practical familiarity with the problems that are being considered and be actively engaged in the practice of the medical subject under discussion.

## CHAPTER XX
## SPECIAL SECTIONS

**Section 1 — Resident Physician Section** — Membership in this section shall include resident physicians who are members in the active category of the Pennsylvania Medical Society as graduates in training.

The section shall elect a governing committee consisting of a chairman, vice chairman, secretary, delegate, and alternate delegate to the PMS House of Delegates, and two members-at-large. The regular functions of this section shall include, but not be limited to, the conducting of a business meeting held in conjunction with the PMS House of Delegates meeting.

**Section 2 — Medical School Section** — Membership in this section shall include deans of Pennsylvania medical

**Section 14 — Reinstatement of Membership After Automatic Suspension** — Chapter XIII, Section 11, page 29 of the current Bylaws explains reinstatement criteria for the automatically suspended member. (See Section 9, Chapter XIX of this revision.) This new section repeats the provision and adds automatic to the section heading for clarity.

**Section 15 — Expulsion of Unqualified Witness** — Chapter XIII, Section 10, page 28 of the current Bylaws provides for expulsion of an unqualified "expert" witness in accordance with bylaws due process provisions. This new section repeats the provision and qualifications of the expert witness.

## CHAPTER XX
## SPECIAL SECTIONS

**Section 1 — Resident Physician Section** — Chapter XVII, Section 1, page 36 of the current Bylaws provides for the Resident Physician Section. This new section repeats that section adding the reference "graduates in training" to be consistent with the variation in the active category of membership.

**Section 2 — Medical School Section** — Chapter XVII, Section 2, page 36 of the current Bylaws provides for the

schools who are active members of the Pennsylvania Medical Society and up to five members of administration or faculty of each Pennsylvania medical school, designated by the dean of the school, who are active members of the Pennsylvania Medical Society. In the event the dean is not an active member of this Society, the dean may designate a representative who is an active member.

The section will elect the governing council consisting of a chairman, vice chairman, secretary, delegate, and alternate delegate to the PMS House of Delegates, and two members-at-large. The regular functions shall include, but not be limited to, the conducting of a business meeting held in conjunction with the PMS House of Delegates meeting. The cost incurred by the participating members of the section should not be a responsibility of the Pennsylvania Medical Society.

### CHAPTER XXI
### AMENDMENTS

The House of Delegates may amend these bylaws at any meeting by an affirmative vote of two-thirds of the delegates present provided the text of the proposed amendment has been:

a. submitted not less than four months, and not more than fifteen months, prior thereto, to a meeting of the House of Delegates, or to the Secretary of this Society by (i) the Committee on Bylaws, or (ii) 15 active or associate members of this Society whose signatures shall be appended thereto; and

b. at least two months prior thereto, published in the journal of this Society, and in the call for the meeting.

The House of Delegates may determine the effective date of any amendment.

These bylaws may be amended at any special meeting of the House of Delegates in the same manner. The House of Delegates may determine the effective date of any amendment.

### CHAPTER XXII
### SEAL

**Section 1 — Description** — This Society shall have a corporate seal which shall contain the monogram "A.M.A." and "1847" within a circle on a keystone at the sides of which shall appear: "Organized 1848: Chartered 1890," and the whole surrounded by a double circle containing the words "Pennsylvania Medical Society."

(Secretary's Note: Three-fourths vote required; Committee proposal in response to 1978 and 1979 House of Delegates actions.)

Medical School Section. This new section repeats the section.

### CHAPTER XXI
### AMENDMENTS

**Section 1 — Methods** — Article XV, page 11 of the current Constitution describes the amendment process for the Constitution. Chapter XVIII, page 37 of the current Bylaws describes the different amendment process for the bylaws.

This new section retains the provisions from the Constitution for amending these bylaws and includes only the reference to amendments permitted at special meetings of the House of Delegates from aforementioned Chapter XVIII.

### CHAPTER XXII
### SEAL

**Section 1 — Description** — Article XIV, page 11 of the current Constitution describes the seal representing the Pennsylvania Medical Society. This new section repeats that descriptive provision.

**SPECIAL NOTE: CHAPTER XV, PENNSYLVANIA MEDICAL CARE PROGRAM has been deleted.**

Chapter XV, page 33 of the current Bylaws describes the Pennsylvania Medical Care Program. The program, under the aegis of the Council on Medical Economics, operates to encourage cooperation among physicians, county medical societies, health insurance carriers, and all other groups interested in high quality health care at reasonable cost.

Since administrative activities of all the councils were deleted from the Bylaws a few years ago, it is logical to delete this language regarding the Medical Care Program since it is an administrative responsibility of a council.

Subjects of such an administrative nature are not quintessential to a set of bylaws, since bylaws need to reflect the corporation's structure and organization and not all administrative activity.

Further, the Council reports on its activities at regular Board meetings and annual meetings of the House of Delegates. Leadership and membership thus will be kept informed.

---

**Subject Two (Revision)**

2. Change in authority to determine the site of a meeting of the House of Delegates.

**Chapter VII — Annual Meeting of the House of Delegates**

Section 1. Designation. There shall be an annual meeting of the House of Delegates which shall convene at a place [previously determined by the House of Delegates] and at such time as determined by the Board of Trustees. The Board of Trustees may cancel or change the date or place of the meeting in case of strikes, government regulations, catastrophes, or other reasons beyond the control of this Society.

(Secretary's Note: Two-thirds vote required; Committee proposal.)

→

**Subject Three (Revision)**
3. Unified Membership
**Chapter I — Membership**
Section 2. Admission to Membership. To be a member of this Society a physician must be a member of a component society *and the American Medical Association.* The term "physician" means a person who has received formal and recognized training in the art and science of medicine and is qualified to acquire an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania.

Once elected to a category of membership other than honorary, in a component society, the member is required to become a member of this Society *and the American Medical Association* within three months by paying any appropriate assessment and having the component society certify to the Executive Vice President of this Society that the member possesses the qualifications for the category as described in these bylaws.
(Secretary's Note: Two-thirds vote required; 1979 House action.)

**Subject Four (Constitution)**
4. Change in authority to determine the site of a meeting of the House of Delegates.
**Article VII — Sessions and Assemblies**
Section 1. Annual Session. This Society and the House of Delegates shall convene in Annual Session at such place [to be determined by the House of Delegates] and at such time to be determined by the Board of Trustees and Councilors, and each session shall continue for three days, or longer if required by the business of this Society. In case of strikes, governmental regulations, catastrophes or other reasons beyond the control of this Society, the Board of Trustees and Councilors shall have the power to cancel or change the date or place of meeting of the Annual Session of this Society.
(Secretary's Note: Two-thirds vote required; Committee proposal.)

**Subject Five (Constitution and Bylaws)**
5. Unified Membership
**Article IV — Membership**
Section 2. Active Members. The active members of this Society shall be physicians who are members of the component societies *and the American Medical Association.*
(Secretary's Note: Two-thirds vote required; 1979 House of Delegates action.)

**Chapter I — Membership**
Section 2. Membership Compulsory. Every member of a component society eligible for membership in this Society as provided in Article IV of the Constitution shall become a member of this Society *and the American Medical Association* within three months after his election to any class of membership therein, unless such member is a provisional or honorary member of the component society, in which event he shall not be required to become a member of this Society *or the American Medical Association* until three months after his election to some other class of membership.
(Secretary's Note: Three-fourths vote required; 1979 House of Delegates action.)

**Subject Six (Bylaws)**
6. Increasing the number of delegates constitution a quorum.
**Chapter III — House of Delegates**
Section 5. Quorum. [Forty] *Seventy-five* voting delegates shall constitute a quorum at any session, annual or special, of the House of Delegates.
(Secretary's Note: Three-fourths vote required; Committee proposal.)

**Subject Seven (Constitution)**
7. Changing the Speaker of the House of Delegates and the Vice Speaker to voting members of the Board of Trustees from nonvoting members.
**Article VIII — Board of Trustees and Councilors**
Section 2. Composition. The Board of Trustees and Councilors shall consist of the President, the President Elect, the Vice President, [and] the Immediate Past President, [ex-officio with the right to vote and] the Speaker and the Vice Speaker of the House of Delegates, ex-officio [without] *with* the right to vote, and one active, senior active, associate, intern or resident member from each Councilor District of this Society as determined by the Bylaws. Each Trustee and Councilor shall be elected for a term of three years and shall serve until his successor shall have been elected and qualified. A Trustee and Councilor may serve three consecutive terms, however, a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than one year and for this purpose a year shall be deemed to be the period between annual sessions of the House of Delegates.
(Secretary's Note: Two-thirds vote required; Committee proposal.)

**Subject Eight (Constitution)**
8. Changing the number of trustees whose terms expire in one year from three to four.
**Article VIII— Board of Trustees and Councilors**
Section 3. Election. The Trustee and Councilor from each Councilor District shall be nominated by the voting members in the House of Delegates from the Councilor District which the Trustee and Councilor is to represent, and shall be elected by all the voting members present at the Annual Session of the House of Delegates at the expiration of the term of the Trustee and Councilor from that Councilor District, or when a vacancy exists as set forth in Section 4 below. [This section shall not be construed to require a new election of any Trustee and Councilor whose term has not expired at the first session of the House of Delegates following the adoption of this section of the Constitution, nor shall it be construed as creating a vacancy in the office of any Trustee and Councilor, it being the intention that the terms] *Terms* of Trustees and Councilors shall continue to be arranged so that the terms of no more than [three] *four* Trustees and Councilors expire at any Annual Session. [as at the time of the adoption of this section.]
(Secretary's Note: Two-thirds vote required; Committee proposal.)

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**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Pennsylvania Medicine

Vol. 83, No. 9 SEPTEMBER 1980

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Reference 1 Hellerstein HK Friedman EH Sexual activity and the postcoronary patient Arch Intern Med 125 987 1970

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SEPTEMBER SPECIAL ISSUE OFFICIAL FOR TRAUMA WEEK

This issue of PENNSYLVANIA MEDICINE is the official publication for Trauma Week in Pennsylvania. Governor Dick Thornburgh has proclaimed October 12-19, 1980 as Trauma Week. Secretary of Health H. Arnold Muller and Mrs. Ginny Thornburgh, whose remarks are on page 24, co-chair the event. J. Stanley Smith, MD, guest editor of the Trauma Section, has an editorial on page 26. PENNSYLVANIA MEDICINE wishes to thank those pharmaceutical manufacturers who responded to a request for special support for this issue. They are McNeil Laboratories, Merck, Sharp & Dohme, Smith, Kline & French, and Wyeth Laboratories. Because this is a special issue, the advertising is not interspersed as usual. Please take note of all the advertisers whose support makes this publication possible.

PMS AND COMMONWEALTH AGREE TO SETTLE SUIT

The Commonwealth of Pennsylvania has agreed to stop withholding from the State Board of Medical Education and Licensure the balance of all registration fees paid by physicians. The medical board now will have control of funds to enable it to enforce the Medical Practice Act. In a stipulation filed in Commonwealth Court August 21, the state also agreed to render to the Pennsylvania Medical Society a complete accounting of all fees collected from doctors and all disbursements made by the medical board to date. The stipulation settles the lawsuit brought by PMS in January 1978. The suit was filed because the state had failed to obey the section of the malpractice law (Act 111 of 1975) which called for use of such fees to carry out the work of the State Board of Medical Education and Licensure in policing the profession. Although PMS agreed to the settlement, PMS Executive Vice President John F. Rineman said, "We understand there are more than 250 complaints on file with the board and awaiting action. This is intolerable." A major problem is the lack of attorneys to process these complaints." When the Board of Trustees agreed to the terms of the settlement at its August 20 meeting, there was indication that another law suit was a possibility. Rineman said, "If, after a reasonable amount of time, we see no improvement, I think the Society will take further action."

COMPUTERS NOW PROCESSING MEDICAL ASSISTANCE CLAIMS

Medical Assistance claims from physicians are being processed, beginning September 1, by a new computer system, Medical Assistance Management Information System (MAMIS). The new billing form (MA 305) is a modification of the AMA uniform claim form. All physicians participating in the Medical Assistance Program are required to sign a one page agreement, which the Department of Public Welfare substituted for a previously offered six page contract. This Individual Practitioner Agreement was the subject of a letter to all PMS members from President Matthew Marshall, Jr., MD, early in August. PMS consented to the modified Individual Practitioner Agreement after exploring alternatives with officials of both

the Pennsylvania Department of Public Welfare and the U.S. Department of Health and Human Services. Negotiations with DPW Secretary Helen O'Bannon continued on August 20, with Dr. Marshall leading the PMS delegation. Among subjects to be explored at future meetings are increasing surgical and procedure fees and increasing the fee for an office visit in the 1981-82 budget. The fee for an office visit went from $6.00 to $8.00 in the 1980-81 budget.

MEDICAID FRAUD ACT EFFECTIVE THIS MONTH

Medical Assistance fraud is a felony for both recipients and providers under Act 105 of 1980, the Medical Assistance Fraud and Abuse Control Act, which became effective this month. The law, signed June 1980, is aimed at curbing the activities of "medicaid mills." It carries a maximum penalty of $15,000 and seven years imprisonment. Targets are those who defraud the Medical Assistance Program through deception. PMS legal counsel is preparing a summary of the act for publication in the October issue of PENNSYLVANIA MEDICINE.

NATION'S HEALTH SPENDING CONTINUES UPWARD SPIRAL

Spending for health care in the nation in 1979 was an estimated $212.2 billion, an amount equal to 9 percent of the gross national product, Patricia Roberts Harris, health and human services secretary announced August 25. On a per capita basis, health spending from all sources was an estimated $943. Of that amount, $406, or 43 percent, represented public spending. The Health Care Financing Administration compiled the figures, which are published in the current issue of its quarterly journal, Health Care Financing Review. For a copy of the fall issue, send a request to ORDS Publications, Room 1E9 Oak Meadows Building, 6340 Security Blvd., Baltimore, MD 21235.

PMS ENDORSES DR. RIAL FOR AMA PRESIDENCY

William Y. Rial, MD, of Swarthmore, speaker of the AMA House of Delegates, was endorsed August 20 by the PMS Board of Trustees for the AMA presidency elect. Already endorsed by the Pennsylvania Delegation to the AMA, Dr. Rial will be a candidate at the AMA Annual Meeting in Chicago in July 1981. He served as speaker of the PMS House of Delegates until his election as vice speaker of the AMA House.

CANCER INSTITUTE BEGINS LAETRILE CLINICAL TRIAL

The first clinical trial of the possible effectiveness of Laetrile (amygdalin) in the treatment of cancer began in July. The National Cancer Institute project is using four cancer research centers simultaneously under the direction of the Cancer Therapy Evaluation Program. Some 200 patients for whom no other treatment has been effective will be involved. They will be given Laetrile, along with a special diet and vitamin supplements. The study may take up to two years to complete.

STATE SOCIETY ADDS ATTORNEY TO STAFF

Executive Vice President John F. Rineman announced at the August 20 Board meeting that Kenneth B. Jones, Esquire has begun his duties as PMS staff attorney. Jones, a 1979 graduate of Boston College Law School, was a member of the Society staff for nearly five years before leaving to attend law school. He had been in the private practice of law in Boston prior to returning to PMS. Pepper, Hamilton & Scheetz remains the Society's counsel of record.

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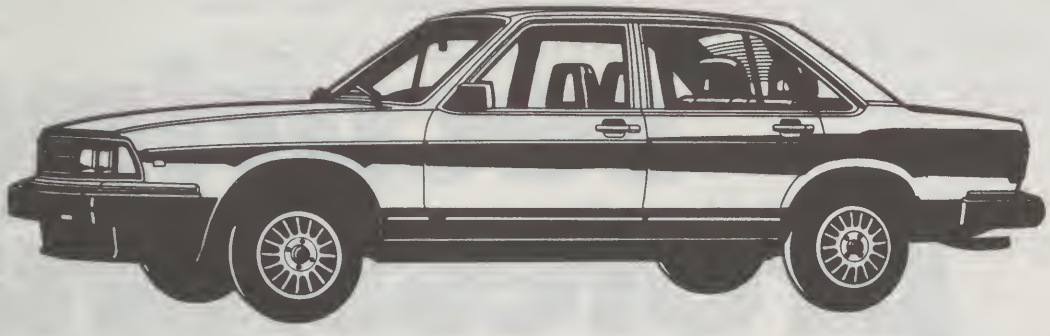

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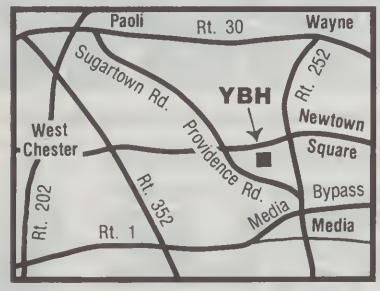


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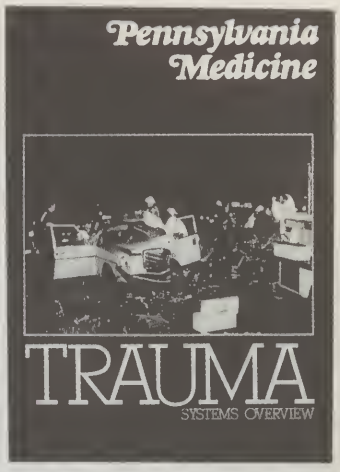


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**PENNSYLVANIA MEDICINE**
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

**PUBLICATION COMMITTEE**
Carol N. Maurer, MD, Chairman, Oil City
Ralph S. Blasiole, MD, Washington
John J. Danyo, MD, York
J. Mostyn Davis, MD, Shamokin
Robert S. Pressman, MD, Philadelphia

**STAFF**
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Medical Editor
Mary L. Uehlein,
Managing Editor
KathyLee Santangelo
Assistant Managing Editor

**CONTRIBUTING EDITORS**
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Edward F. Sickel, MD, Harrisburg

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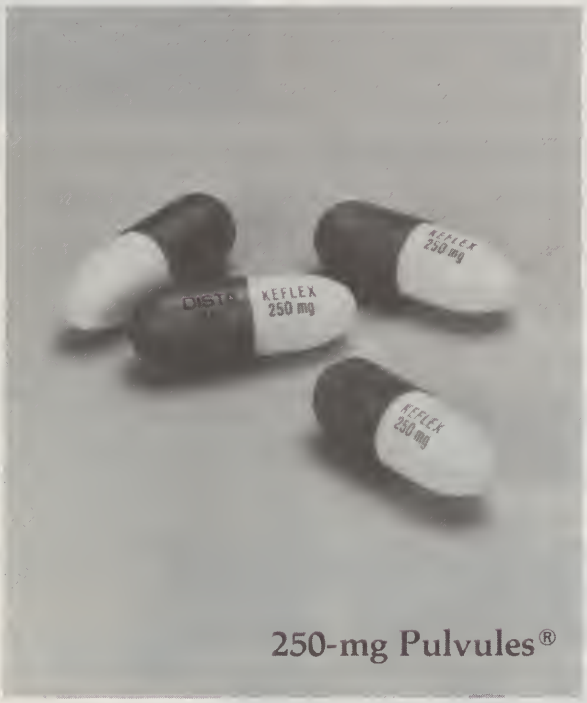

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# newsfronts

## Jonathan Rhoads receives AMA's Sheen Award

The board of trustees of the American Medical Association recently selected Jonathan E. Rhoads, MD, as the recipient of its Dr. Rodman E. Sheen and Thomas G. Sheen Award for 1979. The award, presented annually to a physician for scientific accomplishment, includes a $15,000 stipend.

The award was presented to Dr. Rhoads at the opening ceremonies of the AMA annual convention in Chicago, July 20. Hoyt D. Gardner, MD, AMA president, announced the award to Dr. Rhoads and noted that "in a distinguished medical career spanning more than four decades, Dr. Rhoads has achieved outstanding accomplishments in his own field of surgery as well as in the field of research and the conquest of cancer."

Dr. Rhoads is professor of surgery at the University of Pennsylvania School of Medicine, and a member of the surgical staff at the Hospital of the University of Pennsylvania.

He received his medical degree from Johns Hopkins University School of Medicine in 1932 and in 1940 received his doctor of science degree from the University of Pennsylvania Graduate School of Medicine.

The Philadelphia surgeon is being recognized by the AMA for his scientific contributions which include nearly 300 published scholarly papers in his name. He is editor of *Cancer,* a journal of the American Cancer Society and he serves on the editorial board of the *Annals of Surgery*. He is a founding member and past editorial board member of the *Journal of Surgical Research*.

In 1975, Dr. Rhoads received the Distinguished Service Award of the Pennsylvania Medical Society, the highest honor awarded by physicians in Pennsylvania to a colleague. He is a past president of the Philadelphia County Medical Society and a delegate to the House of Delegates of the Pennsylvania Medical Society.

He is a past president of the American College of Surgeons, a past president of the American Surgical Association, and a past president of the American Cancer Society. Since 1976, he has been president of the American Philosophical Society, an organization founded in 1743 by Benjamin Franklin.

A past member of the board of public education of the city of Philadelphia, Dr. Rhoads has received numerous honors for his service to mankind including the American Cancer Society's National Award, the Distinguished Service Award from the American Surgical Association, and the Distinguished Service Award from the American Trauma Society.

### International meeting of family physicians

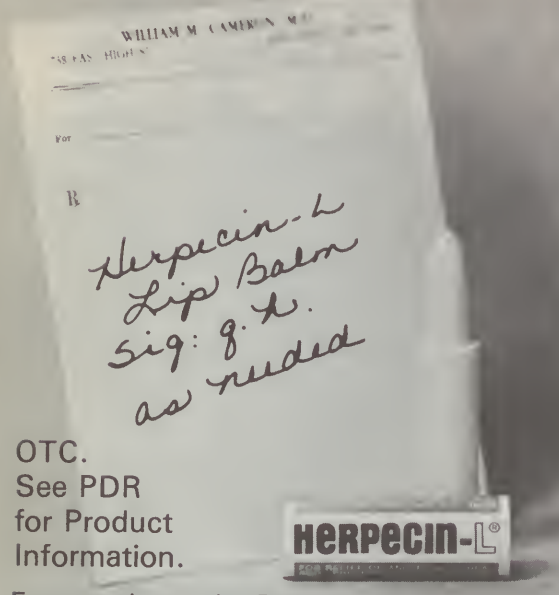
The world's two major family practice groups will stage their scientific assemblies in a joint conference for the first time October 4-9, 1980 at the Rivergate Exhibition Center in New Orleans, Louisiana.

The two groups are the American Academy of Family Physicians (AAFP) and the World Organization of National Colleges, Academies and Academic Association of General Practitioners/Family Physicians (WONCA).

The 48,000-member AAFP is the nation's second largest medical group. Twenty-eight nations are members of the WONCA. Together, the two groups expect to attract 7,000 family physicians from around the world to participate in their continuing medical education conclaves.

The theme for this joint international medical forum is "A World of Caring."

# Dx: recurrent herpes labialis

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**Brief Summary of Prescribing Information**

**Indications and Usage:** Symptomatic relief of anxiety, tension, agitation, irritability and insomnia associated with anxiety neuroses and transient situational disturbances; anxiety associated with depressive symptoms and as a treatment of symptoms of anxiety if such symptoms are a significant feature of functional or organic disorders, particularly gastrointestinal or cardiovascular

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

**Contraindications:** Known sensitivity to benzodiazepines or acute narrow-angle glaucoma

**Warnings:** Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients on lorazepam not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

**Precautions:** In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation

Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions

Observe usual precautions with impaired renal or hepatic function.

Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component

Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (approximately 6 times the maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatric patients requires caution and frequent monitoring for symptoms of upper G.I. disease.

Safety and effectiveness in children under 12 years have not been established

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug.

In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk

**Adverse Reactions,** if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

**Overdosage:** In management of overdosage with any drug, bear in mind that multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring of vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined

# Ativan® IV for (lorazepam) Anxiety

***Dosage:*** **Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.**

***How Supplied:*** **0.5, 1.0 and 2.0mg tablets.**

Wyeth Laboratories
Philadelphia, PA 19101

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# Why one benzodiazepine and not another?

Are you concerned about long-acting metabolites? Many clinicians, as well as pharmacologists, are beginning to draw attention to this problem (see New England Journal of Medicine, April 5, 1979).

In contrast to some older benzodiazepines, Ativan (lorazepam) does not give rise to long-lasting active metabolites. As with all benzodiazepines, you should follow the usual precautions concerning co-administration with other CNS depressants and warn your patients against operating dangerous machinery and motor vehicles.

However, it is noteworthy that Ativan showed no clinical evidence of accumulation even when given in high doses over periods up to 6 months. The half-life of free lorazepam is about 12 hours; steady-state serum levels are attained in 2-3 days. Comparable data for diazepam: 20-50 hours and at least 7-10 days. (The pharmacokinetic profile of a drug can define such characteristics as absorption, distribution, metabolism and elimination but cannot, at present, be directly related to its therapeutic effectiveness.)

Ativan has a convenient b.i.d. or t.i.d. dosage schedule; it is compatible with a long list of other medications and, of course, it is a highly effective anxiolytic agent, as established in numerous nationwide, double-blind, controlled evaluations in thousands of patients.

See important information on preceding page.

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**Anxiety**

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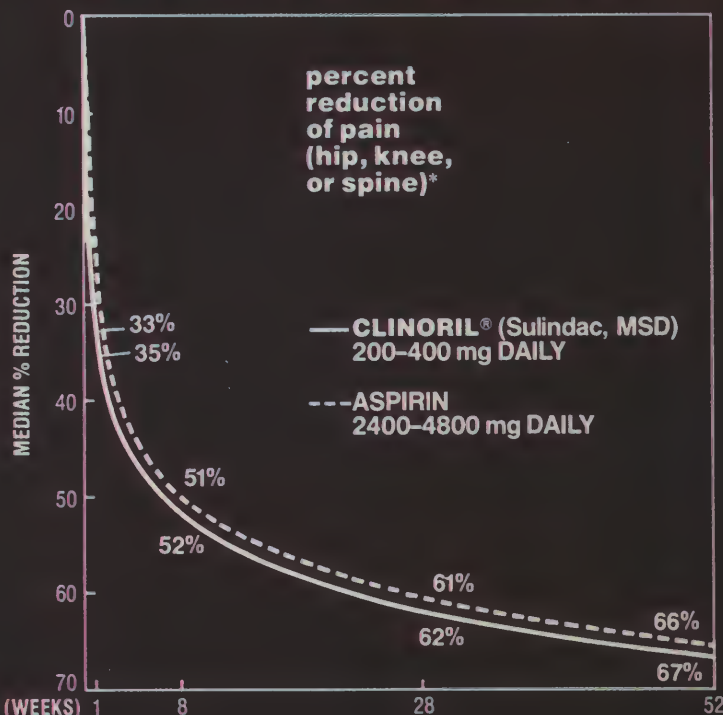
## comparable to that of therapeutic doses of aspirin




| TIME (WEEKS) | 1 | 8 | 28 | 52 |
|---|---|---|---|---|
| Number of Patients on CLINORIL | 183 | 163 | 119 | 91 |
| Number of Patients on Aspirin | 165 | 150 | 95 | 75 |

*Degree of pain was rated on a 0 to 4 scale at each evaluation point. Analysis of median percent change from baseline included only those patients who completed each time period.

Data on file, Merck Sharp & Dohme Research Laboratories.

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TABLETS, 150 mg and 200 mg

# Clinoril®
# (Sulindac | MSD)

## with significantly fewer adverse reactions than with aspirin

| Adverse reactions with CLINORIL and aspirin as reported in comparative clinical trials† (incidence greater than 1% for either drug) | | | |
|---|---|---|---|
| System | Reaction | Percent Occurrence with CLINORIL | Aspirin |
| Gastro-intestinal | GI Pain | 10.2% | 19.4% |
| | Dyspepsia | 9.1 | 24.0 |
| | Nausea | 6.2 | 14.0 |
| | Diarrhea | 4.2 | 3.4 |
| | Constipation | 3.0 | 6.1 |
| | Vomiting | 2.4 | 3.0 |
| | Flatulence | 1.7 | 3.6 |
| | Anorexia | 1.1 | 0.8 |
| | GI Cramps | 1.1 | 1.6 |
| | Peptic Ulcer | 0.4 | 1.3 |
| CNS | Dizziness | 4.2 | 6.7 |
| | Headache | 3.7 | 3.0 |
| | Nervousness | 1.1 | 0.3 |
| Derma-tologic | Rash | 3.0 | 2.7 |
| | Pruritus | 1.1 | 1.5 |
| Otologic | Tinnitus | 2.1 | 19.9 |
| | Decreased Hearing | 0.3 | 6.1 |
| Other | Edema | 1.5 | 1.9 |
| | Fatigue/Tiredness | 0.8 | 1.4 |
| | Sweating | 0.9 | 1.2 |

†Total patients in the clinical studies include 1,865 on CLINORIL and 834 on aspirin. Some of the trials involved comparisons with drugs other than aspirin.

In studies comparing CLINORIL 200 to 400 mg daily with aspirin 2400 to 4800 mg daily in osteoarthritis, CLINORIL was generally well tolerated and patients had a significantly lower overall incidence of total adverse effects, of milder gastrointestinal reactions, and of tinnitus than with aspirin.

## with far fewer tablets daily

**usual starting dosage: 150 mg b.i.d.**
The dosage may be lowered or raised depending on the response.

**maximum recommended dosage: 200 mg b.i.d.**

CLINORIL® (Sulindac, MSD) is contraindicated in patients who are hypersensitive to this product or in whom acute asthmatic attacks, urticaria, or rhinitis is precipitated by aspirin or other nonsteroidal anti-inflammatory agents. CLINORIL is not recommended for use in pregnant women or in nursing mothers.

Peptic ulceration and gastrointestinal bleeding have been reported.

If an abnormal liver function test occurs, it should be monitored until it returns to normal. If a significant abnormality persists, CLINORIL should be discontinued and should not be reinstituted (see ADVERSE REACTIONS).

If evidence of hypersensitivity occurs, CLINORIL should be discontinued and not reinstituted (see ADVERSE REACTIONS).

CLINORIL should be given with food.

**For a brief summary of prescribing information, please see following page.**

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For many patients with osteoarthritis

# Count on Clinoril®

## (Sulindac | MSD)

**Contraindications:** Hypersensitivity to this product, patients in whom acute asthmatic attacks, urticaria, or rhinitis is precipitated by aspirin or other nonsteroidal anti-inflammatory agents.

**Warnings:** Peptic ulceration and gastrointestinal bleeding have been reported. In patients with active gastrointestinal bleeding or an active peptic ulcer, an appropriate ulcer regimen should be instituted, benefits of therapy must be weighed against possible hazards, and the patient's progress carefully monitored; in patients with a history of upper gastrointestinal tract disease, CLINORIL (Sulindac, MSD) should be given under close supervision and only after consulting the Adverse Reactions section.

**Precautions:** *General*—Although the effect on platelet function and bleeding time is less than with aspirin, CLINORIL is an inhibitor of platelet function; therefore, patients who may be adversely affected should be carefully observed when CLINORIL is administered. Abnormalities in liver function tests, particularly elevated alkaline phosphatase, usually transient, may occur; abnormal liver function should be monitored until it returns to normal, and if significant abnormality persists CLINORIL should be discontinued and not reinstituted (see Adverse Reactions). If hypersensitivity occurs, CLINORIL should be discontinued and not reinstituted (see Adverse Reactions). Because of reports of adverse eye findings with nonsteroidal anti-inflammatory agents, it is recommended that patients who develop eye complaints during treatment have ophthalmologic studies. Since sulindac is eliminated primarily by the kidneys, patients with significantly impaired renal function should be closely monitored and a reduction of daily dosage may be anticipated to avoid drug accumulation.

Peripheral edema has been observed in some patients taking CLINORIL. Therefore, as with other nonsteroidal anti-inflammatory drugs, CLINORIL should be used with caution in patients with compromised cardiac function, hypertension, or other conditions predisposing to fluid retention.

CLINORIL may allow a reduction in dosage or the elimination of chronic corticosteroid therapy in some patients with rheumatoid arthritis. However, it is generally necessary to reduce corticosteroids gradually over several months in order to avoid an exacerbation of disease or signs and symptoms of adrenal insufficiency. Abrupt withdrawal of chronic corticosteroid treatment is generally not recommended even when patients have had a serious complication of chronic corticosteroid therapy.

*Use in Pregnancy*—Not recommended for use in pregnant women, since safety for use has not been established.

*Nursing Mothers*—Nursing should not be undertaken while a patient is on CLINORIL. It is not known whether sulindac is secreted in human milk; however, it is secreted in the milk of lactating rats.

*Use in Children*—Pediatric indications and dosage have not been established, but studies in juvenile rheumatoid arthritis are in progress.

*Drug Interactions*—Although sulindac and its sulfide metabolite are highly bound to protein, studies with daily doses of 400 mg have shown no clinically significant interaction with oral anticoagulants or oral hypoglycemic agents; however, patients should be monitored carefully until it is certain that no change in their anticoagulant or hypoglycemic dosage is required. Special attention should be paid to patients taking higher doses than those recommended and to patients with renal impairment or other metabolic defects that might increase sulindac blood levels. Concomitant administration of aspirin significantly depressed the plasma levels of the active sulfide metabolite, and the combination cannot be recommended. Probenecid given concomitantly had only a slight effect on plasma sulfide levels, while plasma levels of sulindac and sulfone were increased; sulindac produced a modest reduction in the uricosuric action of probenecid, which probably is not significant under most circumstances. Neither propoxyphene hydrochloride nor acetaminophen had any effect on the plasma levels of sulindac or its sulfide metabolite.

**Adverse Reactions:** The adverse reactions listed in the following table have been arranged into two groups: (1) incidence greater than 1%, and (2) incidence less than 1%. The incidence in group (1) is based on observations in clinical trials in 1,865 patients, including 232 observed for at least 48 weeks. The incidence in group (2) is based on these clinical trials or on reports received since the drug was marketed. The most frequent types of adverse reactions occurring with CLINORIL are gastrointestinal. The probability of a causal relationship exists between CLINORIL and the following adverse reactions:

**Incidence greater than 1%**

| |
|---|
| *Gastrointestinal*<br>gastrointestinal pain (10%)<br>dyspepsia*<br>nausea* with or without vomiting<br>diarrhea*<br>constipation*<br>flatulence<br>anorexia<br>gastrointestinal cramps |
| *Dermatologic*<br>rash*<br>pruritus |
| *Central Nervous System*<br>dizziness*<br>headache*<br>nervousness |
| *Special Senses*<br>tinnitus |
| *Miscellaneous*<br>edema (see Precautions) |

*Incidence between 3% and 9%. (Those reactions occurring in less than 3% of patients are unmarked.)

**Incidence less than 1%**

| |
|---|
| *Gastrointestinal*<br>gastritis or gastroenteritis<br>peptic ulcer (1 in 250)<br>gastrointestinal bleeding (1 in 600)<br>GI perforation<br>liver function abnormalities<br>jaundice, sometimes with fever<br>cholestasis<br>hepatitis<br>pancreatitis |
| *Dermatologic*<br>stomatitis<br>sore or dry mucous membranes<br>erythema multiforme<br>toxic epidermal necrolysis<br>Stevens-Johnson syndrome |
| *Cardiovascular*<br>congestive heart failure in patients with marginal cardiac function<br>palpitation |
| *Hematologic*<br>thrombocytopenia<br>leukopenia<br>increased prothrombin time in patients on oral anticoagulants (see Precautions) |
| *Central Nervous System*<br>vertigo |
| *Special Senses*<br>blurred vision |
| *Hypersensitivity Reactions*<br>anaphylaxis<br>angioneurotic edema<br>hypersensitivity syndrome consisting of some or all of the following: fever, chills, skin rash, changes in liver function, jaundice, leukopenia, and eosinophilia; rarely, fatalities have been reported |

**Causal relationship unknown:** Other reactions have been reported in clinical trials or since the drug was marketed but occurred under circumstances where a causal relationship could not be established. However, in these rarely reported events, that possibility cannot be excluded. Therefore, these observations are listed to serve as alerting information to physicians.

*Cardiovascular*—Hypertension.

*Hematologic*—Bone marrow depression, including aplastic anemia.

*Nervous System*—Paresthesias, neuritis.

*Special Senses*—Transient visual disturbances, decreased hearing.

*Respiratory*—Epistaxis.

*Psychiatric*—Depression; psychic disturbances, including acute psychosis.

*Genitourinary*—Vaginal bleeding; hematuria; azotemia, usually in patients with preexisting renal disease.

**Management of Overdosage:** In the event of overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage, and the patient carefully observed and given symptomatic and supportive treatment.

**How Supplied:** Tablets CLINORIL (Sulindac, MSD) containing 150 mg sulindac, in bottles of 100; tablets CLINORIL containing 200 mg sulindac, in bottles of 100.

*For more detailed information, consult your MSD representative or see full prescribing information.* JOCL13(004)

MSD
MERCK SHARP & DOHME

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Legal counsel reports

# Court rules hospital owns patient's medical records

**Fred Speaker, Esq.**

The Pennsylvania Supreme Court, in a recent decision,[1] filled in some of the missing parts in the patchwork of law dealing with the confidentiality of medical records. In that decision, Chief Justice Eagen, speaking for three justices, held for the first time that a patient's medical records are owned by the hospital. He stated:

> In this Commonwealth, medical records are the property of the hospital and are not to be removed from the hospital premises except for court purposes. 28 Pa. Code §115.28. Thus, while patients must be given access to, or copies of, their medical records in accordance with the *Patient's Bill of Rights,* 28 Pa. Code §§103.21-103.24, they are not the owners of the records and the hospital cannot be considered merely a custodian.[2]

The administrator of West Allegheny Hospital had refused to comply with a subpoena seeking production of the actual tissue reports of a number of patients on the basis that disclosure would breach confidentiality. The supervising judge held that the administrator was in civil contempt of court.

On appeal, the administrator argued that the statutory physician-patient privilege[3] required the hospital not to produce the records. Chief Justice Eagen stated:

> Here, the subpoenaed tissue reports contain no statutorily privileged communications. While identifying data, such as patient's name and address, would tend to reveal communications by the patient, such communications would in no way tend to blacken the character of a patient. The remaining information on the tissue reports was not gained as a result of communications by the patient.[4]

The administrator raised, in addition, the constitutional right to privacy, first raised in Pennsylvania in the case of *In Re: "B".*[5] Chief Justice Eagen considered this argument but found that it was inapplicable in the specific case:

> Clearly, the privacy interest of the patients which is implicated under the instant set of facts is the interest in avoiding disclosure of personal matters. This privacy interest finds explicit protection in the Pennsylvania Constitution, Art. 1, §1, which provides, in pertinent part: "All men . . . have certain inherent and indivisible rights, among which are those . . . of acquiring, possessing, and protecting property and reputation. . . ." Disclosure of confidences made by a patient to a physician, or even of medical data concerning the individual patient could, under certain circumstances, pose such a serious

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*


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threat to a patient's right not to have personal matters revealed that it would be impermissible under either the United States Constitution or the Pennsylvania Constitution. However, such circumstances do not exist in this case. . . . Considering the factual nature of the data required by the grand jury for the purpose of investigating parties unrelated to the patients themselves and the considerable protection offered by both the terms of the Investigating Grand Jury Act and the responsibility and discretion reposed in the supervising judge, we find neither the United States Constitution nor the Pennsylvania Constitution offended.[6]

This plurality opinion was concurred in by two additional justices, thus comprising a clear majority. In a dissent by Justice Flaherty, it was pointed out that the constitutional right of privacy received only illusory protection in the secrecy of the Grand Jury. In the other dissent by Justice Larsen it was stated that:

> The majority now carves a large hole in this right [of privacy] by, in effect, stating that if recipients are sworn to secrecy, they can then receive this information without breaching this important right. I do not agree.

Thus, it appears that there is general agreement that the right of privacy exists in a physician-patient relationship and can be breached only under special circumstances.

In another case decided in Lancaster County, the Court of Common Pleas held that, although there could be no summary judgment for damages:

> Adopting the reasoning of Alexander,[7] Hague[8] and Hammonds[9] and recognizing the policy reflected by the constitutional holding of two justices in *In Re: "B"*,[10] this court holds that a physician has a legal duty to maintain confidentiality of information arising from the physician-patient relationship unless compelled to testify during litigation.[11]

1./ *In Re: The June 1979 Allegheny County Investigating Grand Jury; Petition of Lanni*, ___ Pa. ___, 451 A.2d 73 (1980).
2./ *Id.*, at 76.
3./ 42 Pa. C.S. §5929.
4./ *Petition of Lanni, supra* at 77. (Citation omitted.)
5./ *Appeal of Dr. Loren Roth*, 482 Pa. 471, 394 A.2d 419 (1978).
6./ *Petition of Lanni, supra* at 77-8.
7./ *Alexander v. Knight*, 25 D&C 2d 649 (1961), aff'd, 197 Pa. Super. 79, 177 A.2d 142 (1962).
8./ *Hague v. Williams*, 37 N.J. 328, 181 A.2d 345 (Sup. Ct. 1962).
9./ *Hammonds v. Aetna Casualty & Surety Co.*, 237 F.Supp. 96, reconsideration denied, 243 F.Supp. 793 (N.D. Ohio 1965).
10./ *In Re: "B"; Appeal of Dr. Loren Roth, supra.*
11./ *Nicholson v. Polcyn Estate*, 12 D&C 3d 561 (Lancaster 1979).

## Are chiropractic services "medical services"?

The argument among Pennsylvania's lower courts about whether chiropractic services are "medical services" continues. The Pennsylvania No-Fault Motor Vehicle Insurance Act[1] provides that a defendant remains liable for damages if the plaintiff paid for medical services in excess of $750.[2] The question is whether chiropractic services should be included in the calculation of what has been paid for medical services.

Last year, a Dauphin County Court of Common Pleas said, "yes;"[3] but a Montgomery Court had answered the same question "no."[4] That answer was affirmed by the Pennsylvania Superior Court.[5]

Now the Dauphin County Court in a new case[6] considers the question once again. It answers "yes" and disregards the Superior Court's order. The Dauphin County Court said:

> We are, of course, bound by the decisions of our appellate court, but this does not extend to the mere affirment of an order of the lower court. Such an order means simply that the appellate court did not choose to disturb the order of the lower court. It does not mean that the reasoning and law of the lower court opinion are adopted by the appellate court; it is no precedent and we are not bound by it.
>
> We stand on our prior decision.[7]

We can expect to hear more about this argument in the future.

1./ 40 P.S. §§1009. 101-1009.701.
2./ 40 P.S. §1009.301 (a) (5) (B).
3./ See *Christini v. Cumberland, Dauphin, Harrisburg Transit Authority*, 101 Dau. 126 (1979).
4./ *Babcock v. Tippett*, 103 Montg. Co. L. R. 110 (1977).
5./ *Babcock v. Tippett*, 260 Pa. Super. 583, 394 A.2d 607 (1978).
6./ *Metz v. Ford*, 102 Dau. 35 (1980).
7./ *Id.* at 36.


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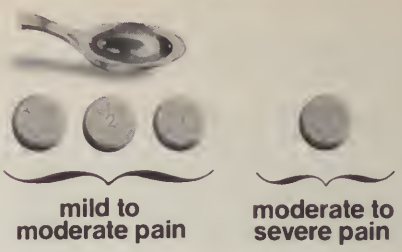

mild to moderate pain

moderate to severe pain

**Summary of Prescribing Information**

**Description**

**Tablets:** Contain codeine phosphate*: No. 1—7.5 mg. (⅛ gr.); No. 2—15 mg. (¼ gr.); No. 3—30 mg (½ gr.); No. 4—60 mg. (1 gr.)—plus acetaminophen 300 mg

**Elixir:** Each 5 ml. contains 12 mg. codeine phosphate* plus 120 mg acetaminophen (alcohol 7%).

***Warning:** May be habit forming.

**Actions:** Acetaminophen is an analgesic and antipyretic; codeine an analgesic and antitussive.

**Contraindications:** Hypersensitivity to acetaminophen or codeine.

**Warnings:** *Drug dependence:* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act.

*Usage in ambulatory patients:* Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

*Interaction with other CNS depressants:* Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.

*Usage in pregnancy:* Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.

*Pediatric use:* Safe dosage of this combination has not been established in children below the age of three.

**Precautions:** *Head injury and increased intracranial pressure:* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

*Acute abdominal conditions:* Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

*Special risk patients:* Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

**Adverse Reactions:** Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.

**Dosage and Administration:** Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. TYLENOL with Codeine tablets are given orally. The usual adult dose is: Tablets No. 1, No. 2, and No. 3: One or two tablets every four hours as required. Tablets No. 4: One tablet every four hours as required. TYLENOL with Codeine elixir is given orally. The usual doses are **Children (3 to 6 years):** 1 teaspoonful (5 ml.) 3 or 4 times daily; **(7 to 12 years):** 2 teaspoonsful (10 ml.) 3 or 4 times daily; **(under 3 years):** safe dosage has not been established. **Adults:** 1 tablespoonful (15 ml.) every 4 hours as needed.

**Drug interactions:** CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For information on symptoms/treatment of overdosage, see full prescribing information.

Full directions for use should be read before administering or prescribing.

TYLENOL with Codeine tablets are manufactured by McNeil Laboratories Co., Dorado, Puerto Rico 00646.

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**Elixir** Each 5 ml contains 12 mg codeine phosphate* plus 120 mg acetaminophen (Alcohol 7%)
***Warning:** May be habit forming.

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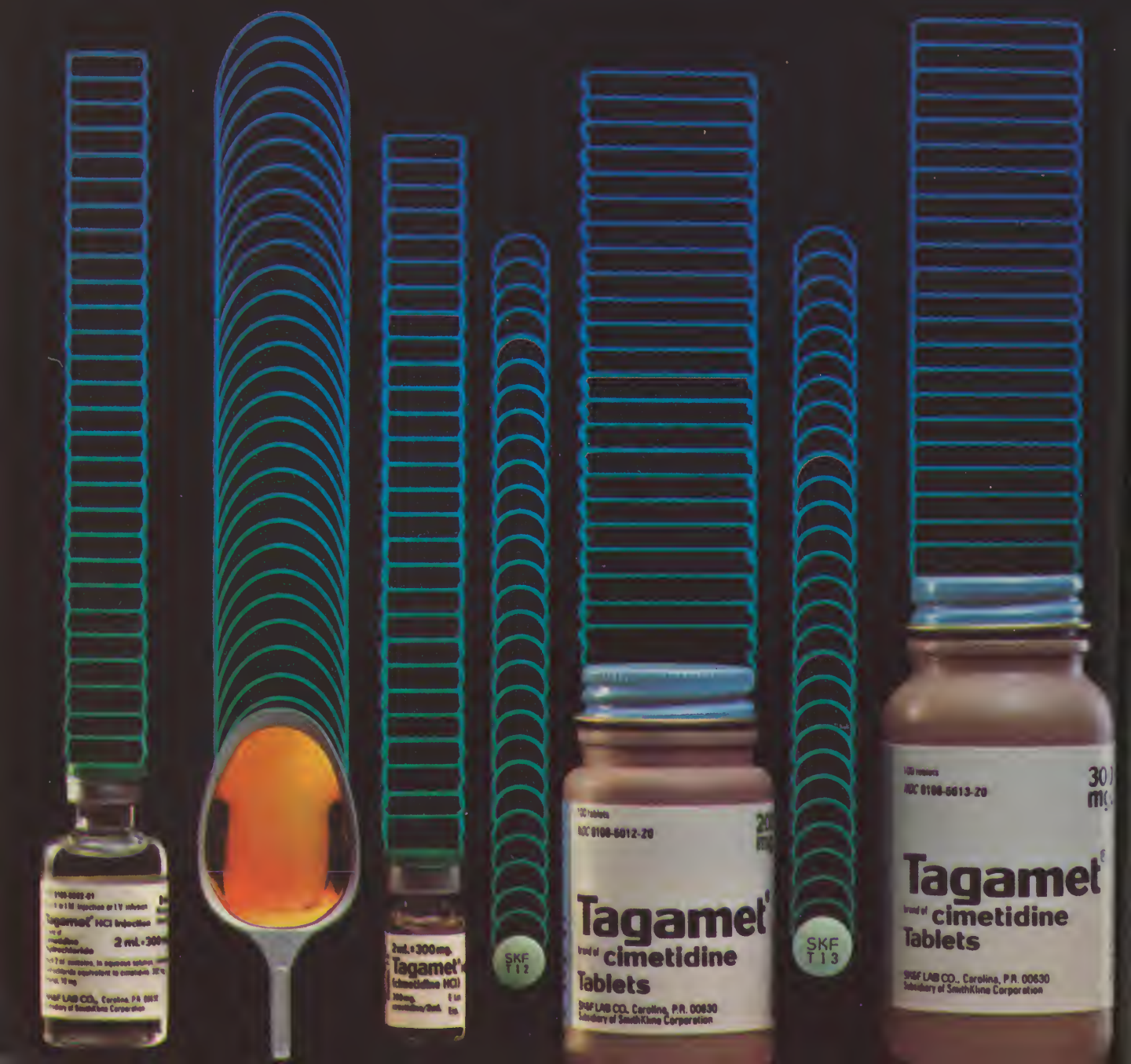

# Med schools join clinical trials group

Philadelphia business leaders and Greater Philadelphia Partnership have joined forces to create the Philadelphia Association for Clinical Trials (PACT), a new nonprofit organization whose goal is to boost economic development.

The organization is being funded initially by grants from SmithKline Corporation and Rorer Group Inc. PACT plans to sell drug companies on using the Philadelphia area, complete with six medical schools, 40 hospitals, and 5.6 million potential subjects, to test their new products.

PACT will match researchers with projects. It will also help with scientific design and protocol, and monitor the studies as they proceed.

Representatives of Thomas Jefferson University, University of Pennsylvania, Temple University Health Science Center, Medical College of Pennsylvania, Hahnemann Medical College and Hospital, and Philadelphia College of Osteopathic Medicine all serve on PACT's board.

According to Lewis W. Bleumle, Jr., MD, president of Thomas Jefferson University, PACT is the first organization of its type in the country. Most existing clinical testing groups, Dr. Bleumle said, are for-profit enterprises that lack the "full backing and approval" of the medical schools.

## Yugoslavian-U.S. scientific meeting in September

The College of Physicians of Philadelphia will host the Second Scientific Meeting of the Yugoslavian-U.S. Medical Association, September 22-24, 1980. The program includes surgery of the head and neck, new procedures in obstetrics and gynecology, and progress in immunology.

The meeting will be held at the College's offices at 19 South 22nd Street, Philadelphia. Conference chairman is Malcolm W. Miller, MD. For additional information contact Pavle Paul, MD, Executive Director, Lankenau Hospital-Research, Lancaster West of City Line Ave., Philadelphia, PA 19151.

**Book review**

# Philadelphia MD, JD explains medicare

Jerry Zaslow, MD, JD, physician attorney in Philadelphia, has written a text for physicians who treat patients covered by medicare.

The book, *Medicare and the Physician,* is published by Legal Aspects of Medical Practice, GMT Medical Information Systems, Division of MFI, Inc., 747 Third Avenue, New York, NY 10017. It costs $14.95.

According to Dr. Zaslow, . . . "the cost of medical care is already borne by the federal government directly through medicare or indirectly through medicaid programs. . . Every physician . . . submits bills to the carrier selected by the Secretary of Health, Education, and Welfare (Health and Human Services as of May 1980). Nevertheless, few physicians understand how the system operates or what it expects of them."

The text succinctly explains how . . . "almost every practicing physician is affected by medicare. All physicians must know how the system works so they can derive the ultimate benefits for themselves and their patients."

The goal of the book is to "help the physician understand and participate in the system while continuing to administer complete and adequate care to his patients."

One important aspect of the text is its details of the duties and obligations under the medicare and medicaid programs. Dr. Zaslow's advice about medicare audits as well as fraud and abuse is critical to today's physicians.

"As a physician participating in the plan, as an advisor to other physicians regarding their rights and responsibilities, and as a representative for others from whom payment has been demanded for overutilization or who are suspected of fraud," Dr. Zaslow is "impressed by the lack of understanding that is commonplace among physicians." He is "firmly convinced that if the physician understands the system, the various statues and rules and regulations implementing it, and if he knows what to expect, he will do what he can to aid the system."


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# PMS Credit Union adopts policy of restraint

The PMS Credit Union adopted on May 15, 1980 the policy established by the Federal Reserve Board on consumer credit restraints.

Loans will be available to buy cars, furniture, appliances, office equipment, and to make home improvements provided that the purchases are used for collateral.

No loans will be made to refinance debts, to pay taxes, or for vacations and travel.

Maximum unsecured loans up to $1,500 are available with a maximum repayment period of 30 months. Maximum secured loans (excluding car loans) are available in amounts up to $5,000 with a maximum repayment period of 60 months.

Amounts up to $5,000 may be borrowed to buy a car provided the borrower has a 20 percent down payment. The maximum repayment period is 48 months.

For used cars, the maximum repayment period varies according to the car's model year. Loans on cars less than three years old can be repaid over a period as long as 36 months. Loans on cars more than three years old must be repaid within 24 months. The used car loan value is determined by the *National Automobile Dealers Association Used Car Guide.*

No limit is placed on the purpose or amount of a loan that is fully secured by credit union shares. To borrow, a shareholder must own and maintain a minimum of 20 shares ($100) and must have been a shareholder for at least six months or employed by the same employer or self-employed for at least one year. Borrowers are urged to repay loans by payroll deduction in amounts equaling or exceeding the monthly payment.

## Surgeon convention slated for October in Atlanta

The 66th annual Clinical Congress of the American College of Surgeons, the largest convention of surgeons in the world, will be held October 19-24, 1980, in Atlanta, Georgia. More than 10,000 surgeons are expected to register for the Congress.

The program includes: 18 postgraduate courses; more than 50 panel discussions and symposia on all surgical specialties; presentations of research-in-progress reports; and a summary of new developments in surgery.

For further information contact Edwin W. Gerrish, MD, Assistant Director, American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611.

## Cancer society schedules day to quit smoking

The Great American Smokeout, scheduled for Thursday, November 20, 1980, is the day smokers across the nation are encouraged to quit smoking.

Last year, the Great American Smokeout had close to 18 million smokers trying to quit for the day.

## The hospital that ate Chicago
# New book on financing informs, amuses

George Ross Fisher, MD, treasurer of the Philadelphia County Medical Society, has written a book entitled, *The Hospital that Ate Chicago* (W.B. Saunders Co., Philadelphia, 1980, $10.95 cloth). The book combines fictional vignettes with serious discussions of the inadequacies of the financial aspects of the medical care system.

The book has a threefold purpose: to recount the history of financing the medical care system; to explain how the financing works today and how it has become distorted; and to offer solutions to the problems.

In a review of the book which appeared in *Forum on Medicine* (May 1980), John R. Gamble, MD, acknowledges that Dr. Fisher "has taken on a formidable task. To explain to other physicians and to the public the complicated problems of financing medical care in hospital is not easy. Interspersed between most chapters are vignettes intended to illustrate points made in the succeeding chapter. Most of these are well done and amusing . . ."

William Weiss, MD, in *Philadelphia Medicine* (June 1980) wrote that Dr. Fisher "has produced a succinct treatise which is entertaining, lucid, and enlightening."

## Blue Shield names Mann

The Pennsylvania Blue Shield Board of Directors has named Leroy K. Mann, Grantham, Pa., as successor designate to PBS President Robert E. Rinehimer, who plans to retire in June 1981.

Mann, currently senior executive vice president, joined PBS in 1952 as administrative assistant. In his 28 years with the company, he has held the positions of general auditor, administrative vice president, vice president-controller, vice president-finance, and executive vice president-finance and administration.

Rinehimer, a native of Wilkes-Barre, Pa., has served as president of PBS since 1970. His retirement will conclude more than 26 years of service with the company.

## Pediatrics academy celebrates golden anniversary

Adolescent health care, sudden infant death, sexual abuse, childhood cancer, sports medicine, and learning disorders will be among the topics discussed when the American Academy of Pediatrics holds its Golden Anniversary Annual Meeting, October 25-30, 1980. Detroit, Michigan, the founding city of the Academy, will host the meeting with headquarters at the Detroit Plaza Renaissance Center.

The meeting will include seminars, plenary sessions, round table discussions, and a keynote address by David E. Rogers, MD, president of the Robert Wood Johnson Foundation.

In recognition of 50 years of advocating children's health and welfare, the academy has adopted ten national child health goals. These goals have been published in a booklet entitled, "An Agenda for America's Children," which will serve as the centerpiece for the academy's anniversary program.

# THE BEST OF BOTH WORLDS

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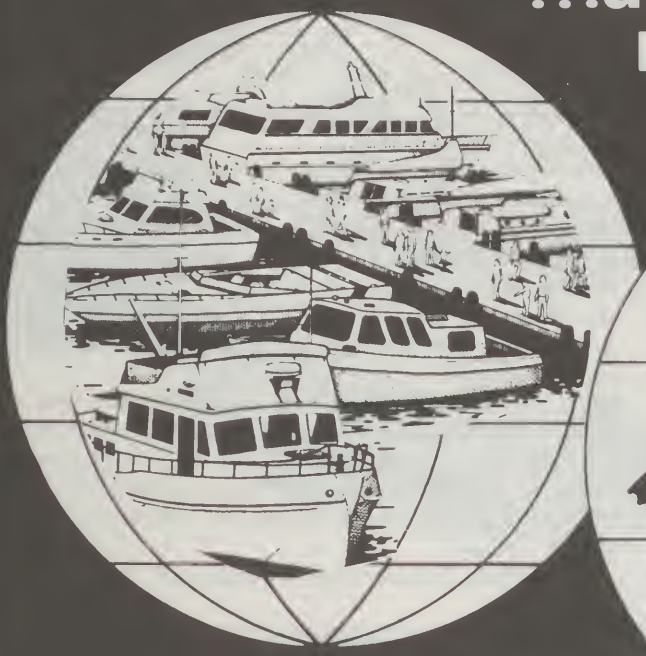

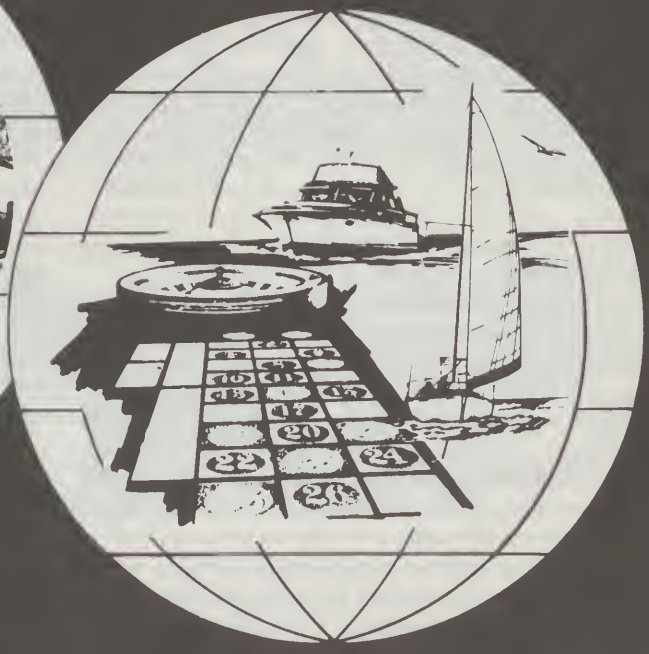

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# editorial

## Special issue observes trauma week, October 12-19

Spinal cord injury and burns are among the most devastating results of trauma.

The neurologic deficit which accompanies acute spinal cord trauma permanently alters the life of the survivor and the lives of the patient's family as well. Not only is the patient deprived of a multitude of physiologic functions but the emotional stress of this type of injury is of no small concern. Total prevention is a commendable but inaccessible goal to achieve.

Management of acute spinal cord injuries has improved greatly during the past decade. With better insight into the pathology of the neurologic injury, the need for a disciplined approach was realized. In an informative paper appearing in this issue of PENNSYLVANIA MEDICINE entitled "The coordinated management of spinal cord injuries," the authors describe the systematized program and its applications for Pennsylvania. The treatment regimen outlined therein is the best medicine has to offer the spinal cord injury patient at present and with which it is well worth familiarizing oneself.

The paper entitled "Burn care in Pennsylvania - 1980" provides an overview of the development and operation of specialized burn care centers in the state since 1970. These specialized facilities represent one of the changes that has revolutionized burn care. The ten hospitals in Pennsylvania currently see about 25 percent of all burn patients in the state. Although advances in the management of inhalation burn injury and in nutritional support of burn patients are the major breakthroughs in treatment, the primary thrust of a burn program must encompass prevention. Educational efforts aimed at reducing burn trauma are essential. It is notable that the Southeast Pennsylvania Health Systems Agency actively has participated in a prevention program, setting a goal for annual reduction at 5 percent.

In addition to these two timely papers, this issue of PENNSYLVANIA MEDICINE includes a number of others pertaining to the organization of trauma services, education for the prevention of trauma, and treatment for trauma victims. Messages from both H. Arnold Muller, MD, and Mrs. Ginny Thornburgh concerning Trauma Week, October 12-19, 1980, also appear in this issue. Both of these noted public figures emphasize the importance of an educational effort for trauma prevention and the development of organized emergency medical services.

David A. Smith, MD
Medical Editor

## Playing a different tune

Remember the doctor at the Medical Society meeting who was all distraught at having to pay a $250 assessment to help launch PMSLIC—the Pennsylvania Medical Society's subsidiary liability insurance company.

"I've been with Medical Protective for 25 years and I don't need PMSLIC," he said. "PMSLIC can't compete premium-wise and I'm not going to pay more for the same coverage."

Well, an interesting thing has happened since then to Medical Protective insureds. In February of this year, their company got an overall statewide increase of 13.5 percent which was weighted against the surgical specialties and this September the company will again increase its rates as follows:

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No question about it, the Medical Protective Company has served its insureds long and well and at rates below all others. However, time changes all things and for many of you it has finally wiped out the premium advantage enjoyed by Med Pro making now a good time to switch to PMSLIC, the doctor-owned and operated company.

David A. Smith, MD
Medical Editor

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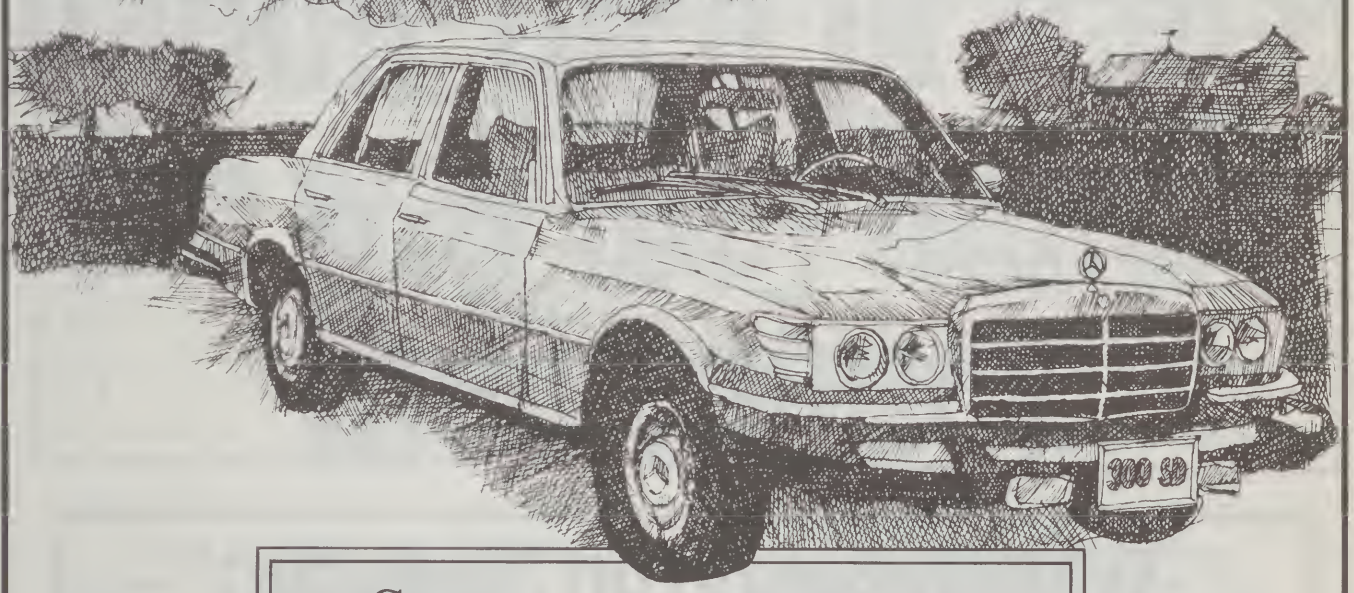

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**Governor Thornburgh has proclaimed the week of October 12-19, "Pennsylvania Trauma Week." Trauma kills more than 4,500 Pennsylvanians each year, and more than 300,000 are injured. Pennsylvania needs a system of trauma prevention and care. The Pennsylvania Division of the American Trauma Society, the Pennsylvania Department of Health, the Pennsylvania Emergency Health Services Council, PMS, and other groups are working toward this goal. This special issue of PENNSYLVANIA MEDICINE is the official publication of trauma week.**

---

I wish to commend PENNSYLVANIA MEDICINE for dedicating this issue to trauma.

Trauma is the most insidious, epidemic disease afflicting our society today. In Pennsylvania, 300,000 are injured each year and over 4,500 die.

There are 383 fire deaths every year in Pennsylvania, yet pressure for improved fire codes and strict enforcement of existing codes is not sustained. Smoke detectors in single family residences, where most fire deaths occur, are not required.

Over half of the yearly 4,500 accidental deaths in Pennsylvania are caused by traffic accidents, yet passive restraints are years away, highway hazards go undetected and uncorrected, and prehospital response systems are understaffed and underfunded. These are mere numbers, but count out loud from one to three hundred eighty-three or from one to 4,500. That is the impact.

The human and economic costs of trauma are unacceptable from any perspective, yet a coordinated, sustained remedial program has not been achieved. Much has been accomplished in the areas of multiple trauma, spinal cord trauma, and burn treatment.

Prehospital emergency care has undergone an almost incredible improvement in the last decade, but there, too, much remains to be done.

The least progress has been made in the most important area - educating our general public. Trauma week is an attempt to begin at least the process of developing an informed, sensitive public.

The Pennsylvania Emergency Health Services Council, the Pennsylvania Trauma Society, the Pennsylvania Chapter of the American College of Emergency Physicians, the Pennsylvania Committee on Trauma of the American College of Surgeons, regional emergency health services councils, and a variety of other concerned and involved organizations have joined together to support the week.

My hope is that it will not stop there. The Pennsylvania Emergency Health Services Council plans 1980-81 initiatives in sports, farm, and industrial trauma; vehicle rescue; and mass casualty responses. The Commonwealth's nine EMS regions continue to struggle to implement effective EMS delivery systems.

The Department of Health supports these efforts with state funds, and I intend to direct each appropriate program in the Department of Health to address the issue of trauma prevention and response.

The Pennsylvania Medical Society has been in the forefront of efforts to define and to attack health problems, and I am pleased that once again my colleagues are addressing an issue that has long been underemphasized.

I invite and encourage participation in the October 12-19 Trauma Week, individual or organizational, and call for continued efforts to reduce the incidence of trauma death and disability as well as to provide the highest quality of medical care when trauma occurs.

H. Arnold Muller, MD
Secretary, Department of Health
Commonwealth of Pennsylvania

I am pleased to join Secretary of Health Muller and many others in supporting Trauma Week.

My involvement with the handicapped citizens of Pennsylvania has taught me that much lifelong pain, suffering, and disability is preventable.

Pennsylvania's medical community can and must provide leadership to reduce the tragic impact of trauma. Too few of our citizens know what to do or whom to call when trauma strikes and fewer still are motivated to prevent it.

It is the medical community that must provide the stimulus to community-wide efforts to *prevent* trauma and to develop easily accessible, prompt, and efficient medical trauma response systems.

Trauma Week, October 12-19, is not just another week. It presents the opportunity to raise the level of public awareness and understanding and thus reduce trauma incidence.

I call upon all physicians to join us in this most important project.

Ginny Thornburgh

# TRAUMA

## SYSTEMS OVERVIEW

# TRAUMA

This issue of PENNSYLVANIA MEDICINE dedicated to trauma is the first of a series of statewide events to call both medical and public attention to the third leading cause of death in the United States, and the number one cause of death in those under 40. In fact, between the ages of 15 and 25, accidents claim more lives than all other causes combined.

There are over 65 million injuries annually and over 100,000 people die. Two million injuries are due to vehicular trauma and 50,000 of those die, accounting for over half of all trauma deaths in only 3.1 percent of all injuries.

Besides killing, trauma maims and disables people in the most productive years of their lives. The economic losses that it causes to our nation total more than $60 billion annually. As with fatalities, half of the economic costs result from motor vehicle accidents. Further, one-third of all hospital admissions are the result of accidents and it is estimated that 22 million bed days are required to provide inpatient care.

Despite the increase in trauma, the civilian sector just now is starting to develop trauma care systems, to organize specialty care centers, and to support the EMS system. The military has led in most of the advances in trauma care, especially following the Korean and Vietnam wars. In these wars, proper early care by paramedical personnel and rapid helicopter evacuation to a "trauma center" proved to reduce significantly mortality and morbidity. At one point, it was actually safer to be injured in Vietnam than on the streets at home.

At home in the continental United States, it has only been in the last ten years that the emergency medical services system has come of age. It has been enacted into law and promulgated beyond Illinois and Maryland. But it all started in Maryland where the clinical research laboratory was translated into the routine care of patients and was applied to a system much like the one the military developed. For the first time, early care by paramedics followed by rapid evacuation to a "trauma center" staffed by specially trained "traumatologists" who applied aggressive antishock therapy could reduce the death and disability caused by our highway carnage.

The Emergency Medical Services System is an attempt to establish a concept of total care for the accident victim. This includes identification of the accident, access to the system, extrication and rescue of the victim, and transport of that victim to a facility appropriate for the care of his injuries. The overall development of such a system not only attempts to assess and train the prehospital sector but also the intra- and interhospital areas. Thus, categorization has become an important tool to identify facilities with special expertise for certain injuries.

The goal of trauma care is to get the severely injured victim to the right people at the right place and at the right time. The most critical period of time after severe trauma is the first "golden hour." Many decisions and interventions during this time will greatly affect a patient's subsequent course. The greatest possible recovery will result from the aggressive treatment by the EMTs, emergency departments, physicians, critical care units, and specialty care centers. As diagnoses are made, these treatments may include the new modalities of technology such as the MAST garment, peritoneal lavage, and the CAT scanner. Only with such an organized and regimented system will the patient derive the greatest benefit - survival.

J. Stanley Smith, MD
Medical Director
Southcentral Pennsylvania
Emergency Services Federation

# TRAUMA

## Trauma systems: Pennsylvania's progress and challenge

George E. Moerkirk, MD, FACS
Joel Grottenthaler

Beginning in the late 1960s national concern produced the beginnings of systems approaches to medical emergencies.[1] The national EMS systems act, passed in 1973, created a federal competitive grant program to plan and implement EMS systems.[2] The latter program was and is administered by U. S. DHEW, now U.S. DHHS.

U.S. DOT had begun efforts to improve prevention and treatment of highway trauma with the passage of the National Highway Safety Act in 1968.[3] Standard 11 of the act addressed emergency health services.

In 1976, the Pennsylvania General Assembly enacted an EMS Systems Act similar to the federal act.[4] Presently, nine regional councils in the Commonwealth are in process. They are completing the planning and development of EMS systems supported by blends of the federal highway safety and EMSS acts, matched by substantial local and state funding.

Governor Thornburgh requested, and the state legislature passed, $2.7 million in state funding for emergency health services for the 1980-81 fiscal year. These funds form the critical match to secure the maximum federal investment in Pennsylvania. The intent of the Pennsylvania and national efforts is to organize the delivery of emergency medical care so that it is promptly accessible, efficiently provided, and appropriate to patient need.

*Dr. Moerkirk is president of the Pennsylvania Emergency Health Services Council, co-medical director of Eastern Pennsylvania EHSC and medical director of Sacred Heart Hospital, Allentown. Mr. Grottenthaler is executive director of PEHSC.*

Trauma systems must be considered within the context of this broad EMS systems concept.

### Incidence and prevention

#### Highway trauma

Traffic accidents account for about half of the mortality and morbidity due to trauma. Some prevention activities have been spurred by the federal Highway Safety Act and other state and federal initiatives, but much remains to be accomplished.

Physical causatives and potentiating factors must be identified and reduced. This already has involved the development of numerous changes in highway design and construction. Light standards that snap off on impact instead of cement bases that force the striking vehicle to give in, and medial guardrails on limited access highways that prevent head-on collisions are two examples.

There remain, however, numerous construction and impact hazards, especially on secondary roadways. Although many of the hazardous locations have been identified, funds for reconstruction have been limited. Trees that line heavily traveled routes still are unprotected by guardrails that could prevent collisions with these and other fixed roadside objects. Hundreds of bridges have solid abutments that permit virtual 90 degree collisions. Poorly banked curves often become subtle but lethal traps to unwary motorists.

Federal and state regulation gradually has brought some semblance of sanity to vehicle design, especially in later model vehicles. Vehicles must be made safe to minimize loss of control and, when collisions occur, maintain the integrity of the passenger compartment. Seatbelts to protect the drivers and passengers have been required, but have not been used often enough.

Passive restraints that are automatic and do not require any action by vehicle occupants will be required beginning in 1982 on all new cars. This requirement, although controversial, should be a key element in the future reduction of traffic accident mortality and morbidity due to head-on collisions.

#### Industrial trauma

General construction recently has replaced deep mining and firefighting as the most hazardous occupation in the country.[5] The federal OSHA act has had some effect, but as in many regulatory programs, OSHA has had difficulty separating the trivial from the consequential, and bringing on change in large companies with well-established legal resources. The consequence is that smaller industries may bear a disproportionate share of agency interest.

One hopeful note is that recent data indicate that training in response to trauma has an effect on the incidence of trauma. One study showed a substantial drop in on-the-job accidents after a factory-wide first aid training program was established.

#### Farm trauma

Recent trends to larger, more sophisticated equipment have led to an alarming increase in farm-related trauma death rates.[6] Due to increased mechanization, more farmers work alone. This has obvious effects on accident discovery and rescue. Farming is now second to general construction in terms of occupational death and disability rate.

The Pennsylvania Emergency

Health Services Council (PEHSC) and others are developing and implementing programs for farmers, their families, and public safety personnel in preventing and managing farm emergencies.[6]

**Burns**

Over 380 persons die annually in Pennsylvania from fire and burns, the elderly and the young (under four), having the highest rates.[7] A state Fire Commissioner's Office has been established, but comprehensive, coordinated prevention programs have been rare due to fragmentation that existed prior to the formation of this Office.

The State Fire School is under the Department of Education; the state fire marshall is under the state police; administration of the Pennsylvania Fire and Panic Act is under the Department of Labor and Industry; and at least four other state cabinet level departments and independent boards and commissions have some fire related jurisdiction and responsibility.

Although appointing a state fire commissioner was an appropriate step, we believe it is obvious that further organization and consolidation is necessary to develop a sustained fire and burn prevention effort.[8] This effort must include increased attention to encouraging smoke detection devices in single family residences, the sources of the majority of fire deaths, and an on-site detection and suppression capability in multi-story and industrial-commercial facilities.

**Sports trauma**

Anecdotal evidence continues to accumulate that sports trauma may be an underestimated source of preventable trauma. Pennsylvanians, formally and informally, participate daily in sports. Efforts to develop increased understanding of the incidence, cause, and prevention of sports related injuries must continue to be made.

## Response

**Public response**

The trauma response system begins when prevention fails. It involves the victim, if able, and anyone near the victim who can assist.

Many economical guides to self help and first aid have been published. In varying degrees of accuracy and effectiveness, they have educated the public as to what to do and not to do when medical emergencies strike. Electronic and print media, at times, have been effective information sources.

The American Red Cross Standard First Aid and Personal Safety course is a 25 hour course for the general public. The Red Cross also offers a programmed learning multi-media course, an 8 hour course of essentials. The Red Cross certified 58,000 persons in Pennsylvania in one or the other of these courses during FY 1978-79 alone.[9]

In 1978, the Pennsylvania Legislature amended the state's "Good Samaritan" Act[10] to reflect several changes in general perceptions about emergency care by the public. The basic intent was to secure legislation that provides some support to those who attempt to assist victims who suffer severe injury or sudden illness, even though common law precedents would probably be sufficient protection. The revised act requires certified Red Cross or Heart Association training to qualify for liability protection.

In general, our impression is that there needs to be increased emphasis on extending the availability of first aid and CPR training to the general

public, and especially in motivating the public to undergo such training.

### Access

At present, about half of the population of Pennsylvania has access to the 9-1-1 police-fire-medical emergency telephone number.[11] A bill in the state House, HB 2176, is expected to be enacted this fall to implement a statewide 9-1-1 system plan developed under previous legislation.

Where 9-1-1 has not been implemented, it appears in some cases that duplicative, low volume, fragmented emergency operations centers (EOCs) have created a situation where implementation costs would be prohibitive. The natural inclination is to question the total 9-1-1 cost for linking multiple centers rather than consolidate the EOCs into a single, cost effective one.

Excited citizens should not be required to sort through a bevy of telephone numbers to get emergency assistance. Where EOCs exist, they should provide cost effective, centralized dispatch and coordination of police, fire, and emergency medical services.

### First responders

Trained citizens must be backed up by trained public safety personnel. The concepts of "echelons of care" and "tiered response" have served to increase emphasis on the role of public safety personnel who are the first officials on the scene, but who are not assigned to emergency medical services delivery as their primary function.

These "first responders" may be police officers, fire fighters, park rangers, or security officers. They must be educated in basic emergency medical care, and in the knowledge that such care is their responsibility until EMS personnel arrive in adequate numbers to continue emergency medical care.

Either of two training courses is recommended by PEHSC for first responders: American Red Cross Advanced First Aid and Emergency Care (approximately 60 hours), or the U. S. DOT "First Responder's" Course (40 hours).

PEHSC has recommended that the advanced Red Cross course be supplemented by CPR, which is not

part of the curriculum even though usually taught; and, in cases where the first responders use oxygen, suction, and several other types of equipment, PEHSC recommends that a special module in these skills be completed. The module is currently under development.

Intervention by trained and equipped first responders in medical emergencies before arrival of emergency medical personnel, and the potential for assistance thereafter, make increased efforts to motivate and educate these first responders in their role in emergency medical care essential.

### Basic life support ambulances

Pennsylvania's Voluntary Ambulance Service Certification (VASC) program was developed to recognize ambulance services providing quality service. Over 25 percent of Pennsylvania's more than one thousand volunteer, commercial, and governmental ambulance services have been certified in just 3 years since the health department developed its program.[12] Pennsylvania is the only state in the nation without legislation that establishes minimum standards for ambulance services. The voluntary program was developed to compensate for this reality.

Since it is unlikely that the VASC program will motivate all services to meet its standards, PEHSC is circulating draft minimum ambulance standards legislation to attempt to reach a reasonable consensus. Ambulance licensure bills have been introduced in each legislative session in this decade by Senator Louis Coppersmith, only to die quietly, without even the dignity of a vote in some cases.

VASC standards define what is generally considered to be basic life support ambulance service: vehicles designed to meet federal DOT standards, equipped to provide basic life support with adjuncts, and staffed by state certified emergency medical technicians. The majority of ambulance services in Pennsylvania are BLS services, and 86 percent are volunteer.[13] Basically, EMT staffed ambulances equipped with oxygen, installed suction, and noninvasive adjunctive equipment are the goal.

Ambulance design has undergone drastic change from the former standard limousine type to vans and truck bodies designed to provide adequate

storage and work space.[14]

An interesting and apparently effective extension of BLS ambulance services is the so-called Quick Response Service (QRS) unit.[15] In rural areas where first responders are not available and ambulance services may not be stationed nearby, fire apparatus or even private vehicles staffed by EMTs or Advanced First Aid personnel are equipped to render basic life support with adjuncts. These respond directly to the scene to assess and stabilize patients until ambulances arrive.

The QRS concept also has been adapted in some urban areas to provide for rapid response by trained personnel.

**Advanced life support**

Advanced Life Support (ALS) involves definitive care performed by specially trained personnel under physician direction. There are certified EMT-Paramedics in Pennsylvania who primarily perform the functions of ALS in prehospital settings.[16] These functions include administration of intravenous fluids and medication, tracheal and esophageal intubation, and defibrillation.

Physician direction comes by radio, most often after assessment of the patient by paramedics and in many cases after interpretation of EKGs transmitted by telemetry to the medical command site. In some cases, physicians rely completely on verbal communication with field personnel, although this generally occurs in mature systems. Studies are underway nationally to determine whether Advanced Life Support systems require telemetric communications capability.

EMT-Paramedic certification, as well as EMT certification, is authorized by ACT 264 of 1976, P.L. 1205. The act has been used to encourage the development of integrated advanced life support systems with clearly designated medical resource centers. These centers are responsible for training paramedical personnel and on-line medical control. Thus, they provide adequate mechanisms for continuous medical audit and evaluation of prehospital care, ALS personnel and treatment modalities.

Two general types of ALS delivery have developed which, although appearing in some areas as hybrid forms, generally apply.[17] The traditional Mobile Intensive Care Unit (MICU) has been used extensively. It is simply a BLS ambulance augmented to provide ALS and staffed by EMT-Paramedics.

In some areas, this type of operation presents a problem in dispatching. A conflict may develop between BLS and ALS service, especially in suburban or rural areas where political jurisdiction is not so clearly defined as in the urban setting.

As an alternative, we suggest separating the patient transport function and ALS treatment function into clearly defined components. This is the second mode of ALS delivery, the "Squad" unit. The squad unit is a vehicle used to convey ALS personnel and equipment to medical emergency scenes but not a vehicle designed to transport patients.

When ALS service is required, ALS personnel accompany the patient after on-scene stabilization in a BLS ambulance. When the patient does not require definitive care, the ALS unit is immediately available for second call responses, and transportation is provided with BLS personnel.

We believe the squad concept to provide unquestionable relative flexibility and hence cost effectiveness when compared with traditional MICUs. In support of this, there are examples of MICUs that have been confined to limited jurisdictional areas, while nearby areas continue to be covered by BLS units. There are contrasting examples of squad units effectively serving larger areas of territory simply because they complement rather than threaten existing services.

One area of concern that should be examined is the occasional appearance of physicians on the scene of medical emergencies. Should medical control be in the hands of the patient's physician? Or should it remain the responsibility of the medical control physician who is in radio communication with the responding paramedic, who has participated in training and supervision of those paramedics, and who is familiar with accepted treatment protocols and modalities? Present protocols that deal with this issue call for the on-scene physician to be placed in direct contact by radio with the medical control physician. In the meantime, it probably would be best to permit emergency intervention by the paramedics as directed by the medical control physician.

Whatever occurs, it must be remembered that paramedics are trained in only a few critical, invasive skills that have been found to reduce mortality and morbidity in severe emergencies. Their training is limited in scope but concentrated in essentials. Their total authority to perform these skills is derived from formal,

recognized medical control. A physician choosing approaches different from the accepted protocol might be advised to transfer responsibility to the paramedics and medical control physician, or perform the treatment himself.

It is also important that all physicians entrusted with medical command to paramedics be thoroughly trained for this function. Ronald Stewart, MD, of the University of Pittsburgh recently completed a medical controller course, and has allowed PEHSC's Medical Advisory Committee to review it. It is anticipated that the Council's position will be that all medical commanders successfully complete this course.

**Emergency departments**

With the almost revolutionary improvements in prehospital emergency medical care, perhaps it was inevitable that the impact on emergency departments would be pronounced and sometimes controversial.

Today's emergency department is a vital link in the patient response chain. In BLS systems, it is the first point at which aggressive, definitive care should begin. In ALS systems, it must be prepared to continue definitive care, as it is the first point at which hands-on physician care begins.

In cases of multiple trauma, the emergency department response may be the most critical variable in determining individual patient outcome. How rapidly a patient is assessed, and how aggressively and promptly life saving intervention occurs, in our minds are the key elements in trauma response. We believe this perception to apply whether the hospital of which the emergency department is a part is capable of providing total stabilization, or whether the role of the emergency department is to stabilize the patient before transfer to another facility that has the required resources.

County and regional protocols that define patient categories and determine patient destination are being developed in Pennsylvania. We believe there are few trauma cases that justify direct transfer from emergency scenes to sophisticated facilities, bypassing adequately staffed and equipped emergency departments. We see early assessment by skilled emergency physicians as an essential in any patient care system. Exceptions could be made for clearly defined cases of severe multiple trauma which the local emergency department is not able to manage optimally.

Adequate emergency department staffing is essential to adequate trauma care. There must be 24 hour in-house emergency physician capability supported by skilled emergency nurses and ancillary care personnel. Twenty-four hour x-ray and some laboratory availability are also important.

Emergency physicians and nurses should be trained to perform the level of activity required by their facility. The Advanced Cardiac Life Support course of the American Heart Association has been available for some time. The Emergency Department Nurses

Association's Core Curriculum course is being implemented statewide, and the recently developed Advanced Trauma Life Support course of the American College of Surgeons will be available this fall in Pennsylvania.

The American College of Emergency Physicians has succeeded in achieving recognition in conjoint board status, and examinations were given initially early this year. Although board certified emergency physicians will not be in adequate supply in this century by most predictions, there are increasing numbers of approved emergency medicine residency programs in Pennsylvania and the nation. The College has stated its intent to preclude any "grandfathering," but this does not alter the fact that skilled general physicians will need to serve in Pennsylvania's emergency departments for some time to come.

**Specialty care**

In 1979, the Pennsylvania Emergency Health Services Council approved facilities assessment guidelines in nine critical care areas. Of the nine, multiple trauma, burns, and spinal cord trauma concern us here.

The guidelines were developed by almost 100 physicians on one or more task forces chaired by H. Arnold Muller, MD, now secretary of health. Dr. Muller was then the medical director of the health department's Division of Emergency Health Services. After the initial drafts were developed by the task forces, the documents were circulated for comment, redrafted, and recirculated to secure input from professional groups and the hospital community.

The task force guidelines, as consensus documents, attempt to define professional and institutional capability based on condition-specific patient criteria. In multiple trauma the guidelines differ from, but are not seen as incompatible with, recent trauma care defintiions set forth by the American College of Surgeons, at least at the advanced level of specialty care.

The PEHSC multiple trauma guidelines recognize three levels of care and include general patient definitions for each level. Although severe multiple system trauma requires sophisticated intervention, PEHSC recognizes that there are gradations of trauma severity that can be handled by community hospitals.

With this less threatening perspective in mind, there are some important upcoming decisions that Pennsylvania will have to make about multiple trauma care. Burn and spinal cord trauma care already have developed into patterns with reasonable consensus supporting them.

Although Pennsylvania's nine EMS regional projects all have become involved in the categorization and designation process with varied results, strong sentiment exists that only a state level initiative, backed by careful evaluation of patient flow beforehand, can achieve satisfactory results.

Secretary of Health Muller, in a letter to regional EMS projects May 16, 1980, said that ". . . macroregional transfers occur more frequently in four critical care areas, including: high level trauma, burns, neonates, and spinal cord injuries."

The future direction of Pennsylvania's efforts are summarized in Dr. Muller's letter:

> As the impetus grows to proceed with the categorization process, the feasibility of implementing a uniform statewide system becomes more realistic. In relationship to the above referenced components . . . it is essential that a statewide agreement be reached concerning the above four critical care areas in reference to assessment guidelines, designation of macro-regional centers statewide, and the development of transfer protocols.
>
> The PEHSC's 1979 Guidelines represent a reasonable consensus, for most critical care areas, on three-tiered capability criteria in nine areas of critical care.
>
> The Guidelines . . . (are) a framework, but success or failure rests upon the conviction that all of the regional councils and individuals involved will see the necessity to organize the delivery of care to benefit the patient, and strive to develop and adopt a system that is fair, workable, and effective.

Frankly, we do not know what the result of the initiative will be. We can say, however, that the PEHSC's role in developing credible consensus will see perhaps its greatest test in the coming year.

## Conclusion

We have attempted above to survey the essentials of trauma care systems development in Pennsylvania. Obviously we have neither considered all issues, nor have we attempted to provide more than a brief synopsis of issues that were treated.

The basic approach of emergency medical services must begin with the patient, and then must carefully examine response alternatives to determine their appropriateness and how they can best be employed.

Just as it should be clear that progress in preventing and limiting the severity of trauma has been made, it should be clear, too, that there is much room to improve Pennsylvania's trauma emergency care response. Some of the answers to accomplishing this goal are on hand, some are not. Where the answers are known, they somehow must be made into reality. Where they are not known, we must find them. Our search will involve asking some sensitive, hard questions, and that is what Pennsylvania's professional medical community needs to do.

### REFERENCES


1. "Death in a Ditch" - National Academy of Science/ National Research Council, Committee on Trauma and Shock, *Accidental Death and Disability*, (Washington, D. C., September 1966).
2. Emergency Medical Services Systems Act of 1973 (P.L. 93-154).
3. Highway Traffic Safety Act of 1966 (P.L. 89-564).
4. Act 265 of 1976, P.L. 1207.
5. National Safety Council, 425 N. Michigan Avenue, Chicago, IL 60610 provides current data on many aspects of accidents.
6. PEHSC has developed resource guidelines for county-wide cooperative seminars dealing with farm trauma and involving the farm and public safety communities.
7. Data from the State Fire Commissioner's Office, Department of Labor and Industry, Harrisburg, PA 17120.
8. "Pennsylvania Burning," - Joint Committee on State Government of the Pennsylvania Legislature, 1976.
9. American Red Cross, Harrisburg Chapter, 230 State Street, Harrisburg, PA 17011.
10. Act 230 of 1978, P.L. 707.
11. Office of Telecommunications, Health and Welfare Building, Harrisburg, PA 17120.
12. Division of Emergency Health Services, Department of Health, Post Office Box 90, Harrisburg, PA 17120.
13. *Ibid.*
14. See the VASC standards or Federal Standard KKK-1822-A.
15. PEHSC has published guidelines for QRS units which are available in limited quantities.
16. ACT 264 of 1976, P.L. 1205.
17. "Advanced Life Support Standards," PEHSC, 1978.

# TRAUMA

## Categorization: matching needs with services

J. Stanley Smith, MD

Categorization has become a dirty word among physicians and hospital administrators perhaps because many do not understand what is involved. What is categorization, or, more specifically, what is facility capability assessment? It is an inventory process to identify the services which a facility can provide to patients according to a predetermined list of criteria developed by experts as being "ideal."

**Why categorization?**

Why is this necessary? Not all hospitals are created equal. Although they may provide excellent patient care, they may not be able to offer the same physical plants, equipment, or staff. Further, the EMS system fails completely when it delivers a seriously injured patient to a facility that is neither staffed nor equipped to handle his problems, especially since the ultimate survival of the shocked and traumatized patient is determined largely in the first hour of his care.[1]

Because of this, the concept of the nearest hospital must be modified to transport the trauma victim to the closest, most expeditious, and most appropriate facility. In nearby Maryland, this system has evolved gradually over fifteen years of hard fought politics. Supporting statistics show a complete reversal of the death/survival numbers when serious victims are taken to trauma centers.[1]

Categorization is not an effort to limit hospital services. It is not an effort to limit progress. It is not an effort to downgrade facilities. It *is* a means to achieve the ultimate goal of delivering a patient to the facility which is ready and can offer the needed services. Thus, it is an effort to show what is *needed* and to *improve* the quality of care.

Categorization also aims to increase efficiency and to contain costs through a concentration of experienced staff and sophisticated equipment. A study in Orange County, California, compared two adjacent systems, one with a trauma center and one with five level one hospitals among which patients were divided. The study shows that the trauma center missed fewer injuries and had fewer preventable deaths than any of the "optimal" hospitals in the non-trauma center system. This is most likely due to the increased awareness, experience, and aggressiveness of the trauma center personnel.[2]

**History**

The modern history of categorization dates back to the 1966 White Paper, "Accidental Death and Disability: The Neglected Disease of Modern Society" prepared by the National Academy of Sciences.[3] In the midst of many recommendations, the Academy advised that facilities be assessed for the capability to care for trauma patients and that criteria be adopted for categorization. The Amer-

*Dr. Smith is a traumatologist affiliated with Polyclinic Medical Center, Harrisburg. He is medical director of the South-central Pennsylvania Emergency Services Federation and serves on the medical advisory committee of the Pennsylvania Emergency Health Services Council.*

ican Medical Association, American College of Surgeons, Joint Commission for the Accreditation of Hospitals and others followed by developing criteria to define levels of care. The most recent update appears in the American College of Surgeons *Bulletin* of August, 1979.[4]

### Methods

There are two basic methods of categorizing: horizontal and vertical. Horizontal categorization assesses the facility as a whole and does not assess specific services.

Vertical categorization is more specific and classifies according to each critical care area. Vertical categorization allows for certain facilities to have special areas of expertise identified but does not require optimal criteria across-the-board. The vertical system allows more for community planning and splitting of services.

Categorization criteria currently are either developed or under development by the Regional Emergency Health Services Councils of Pennsylvania. Through their grant funding process, the councils are required to assess all facilities within their regions and develop a classification system. Categorization, however, is not complete without designation. Once a facility has been determined to have special expertise in a field, it must be identified as such.

### Common misconceptions

Many discussions of categorization lead to expressions of paranoia and parochialism. The three basic fears are that the patient will lose his freedom of choice, that medical judgment will be usurped by bureaucrats, and that patients will be "stolen," disrupting the normal referral patterns.

Lower level facilities also may fear a loss of prestige and respect to the "center." Others feel that medical command will direct patients toward facilities with empty beds so that beds are not lost in future planning activities.

The answers to these fears come mostly from the nature of the disease itself. Trauma victims often do not or cannot choose a hospital. The medical community, most often, controls the entire system. The only "stolen" patients are those who should have been transferred because they clearly belong in a center.

The categorization process seems to me to be progressive. It allows for community planning for the future. It encourages cooperation between hospitals and more efficient use of services. The process may decrease costs for use of highly technical equipment. Most certainly, categorization increases physicians' awareness of the trauma problem and enhances their education.

One of the positive aspects of categorization will be to identify deficiencies currently present. For instance, as our survival rates increase, we will produce an influx of moderately to severely disabled people into our society. This will require more rehabilitative and skilled nursing care. It may also lead to an increased public awareness of the trauma problem and instigate programs geared toward *prevention*.

### Conclusion

Categorization is an inventory process in which existing services are matched against a matrix of ideal criteria to classify a facility's capabilities. This schema then can be developed into a manual to facilitate transfers. Integrating this with the developing EMS system should provide the trauma victim with the best emergency medical care possible both in the prehospital and intrahospital phases. Such a system would approach the goals of increasing survival, decreasing morbidity, and especially decreasing the subsequent disability and burden on society.

### REFERENCES

1. **Cowley, R.A.:** The resuscitation and stabilization of major multiple trauma patients in a trauma center environment. *Clin Med 83:*14, 1976.
2. **West, J., Trunkey, D.:** Systems of trauma care: A study of two counties. *Arch Surg 114:*455, 1979.
3. *Accidental death and disability: The neglected disease of modern society.* National Academy of Sciences/ National Research Council, Washington, D.C. 1966.
4. Hospital resources for optimal care of the injured patient. *Bull Am Coll Surg* August, 1979.

# TRAUMA

## Burn care in Pennsylvania, 1980

**Peter A. Brigham**
**Frederic A. DeClement, MD**

Much has occurred in Pennsylvania concerning burn care since 1971, when PENNSYLVANIA MEDICINE published a report of the Pennsylvania Medical Society's 1970 Commission on Emergency Medical Services. One of the commission's goals stated that "specialized hospital units . . . . should be available on a regional basis," and this has, in fact, been accomplished in burn care.

### Referral regions

During the past decade, regional referral patterns have developed around ten hospitals in the state, now recognized as being capable of rendering optimal care to patients who have sustained severe thermal injury (see Table 1). These referral regions range from the small area surrounding York Hospital to the multi-state referral regions served by burn centers in Erie, Pittsburgh, and the Philadelphia region.

Pennsylvania's ten burn-oriented hospitals admit an estimated 1,000 thermally injured patients per year, or about 25 percent of all such patients hospitalized throughout the state. The smaller, specialized facilities admit between 50 and 100 burn patients annually. The larger centers at Crozer-Chester Medical Center (19 beds), Saint Agnes Medical Center (11 beds), and The Western Pennsylvania Hospital (14 beds) admit approximately 200 burn injured patients per year.

Development of specialized burn care was spurred in the early 1970s when need studies were carried out by health planning agencies in the Pittsburgh and Philadelphia areas. These were among the first such studies in the nation. The Philadelphia experience, in particular, is a classic example of sound regional planning.

In 1971-72, Regional Comprehensive Health Planning, Inc. (RCHP), the health planning agency for the five-county Southeastern Pennsylvania area, assessed both the need and the demand for specialized burn care. They surveyed all hospitals in the region to determine both the number of hospitalized burn patients and the willingness of hospitals to use specialized facilities, once developed.

Survey results supported the establishment of two burn centers. RCHP then solicited proposals from area hospitals, and early in 1973 endorsed the burn center plans of Crozer-Chester and Saint Agnes Medical Centers. In November 1973 Crozer-Chester admitted the first patient to its burn center, and Saint Agnes followed suit in July 1974. By early 1975, occupancy rates for the two centers had achieved reasonable stability. Since then, occupancy rates have averaged 75 to 80 percent annually, a figure considered ideal for such specialized units.

Before the two centers opened, RCHP encouraged representatives of the two hospitals to meet to establish a burn center consortium. The purpose of the consortium, which is unique nationally, was to share referrals, coordinate promotion and fund-raising efforts, and sponsor joint education programs.

Many of these consortium functions soon were absorbed into the Burn Foundation of Greater Delaware Valley, whose board of trustees is a blend of hospital and community representatives. In addition to supporting the burn center consortium, which recently has added Allentown & Sacred Heart Hospital and St. Christopher's Hospital for Children to its membership, the Burn Foundation has developed one of the country's most vigorous and sustained burn prevention programs.

### Air transport

Part of the funds raised by the Foundation support a helicopter transfer service. About 75 percent of the consortium's burn patients are admitted following referral from another hospital. Between 25 and 30 percent of these referrals are transferred by helicopter, including almost all transfers of over 30 miles.

A recent evaluation of this program studied all helicopter transfers to Crozer-Chester over a two-year peri-

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*Mr. Brigham is president of the Burn Foundation of Greater Delaware Valley, a consortium of burn centers at Crozer-Chester Medical Center, Saint Agnes Medical Center, Allentown & Sacred Heart Hospital Center, and St. Christopher's Hospital for Children. Dr. DeClement is medical director of the Saint Agnes Burn Center.*

**TABLE 1**
**Specialized Burn Care Services in Pennsylvania[1]**

| *City* | *Medical center or hospital* | *Patient referral telephone number* | *Burn beds* | *Burn care director or active physician* |
|---|---|---|---|---|
| Allentown | Allentown & Sacred Heart | 215/821-2058 | 6 | W. J. Okunski |
| Chester | Crozer-Chester | 215/876-0356 | 19 | C. E. Hartford |
| Danville | Geisinger | 717/275-6353 | 4 | P. C. Breen |
| Erie | Hamot | 814/455-0066 | 8 | C. R. Bales<br>F. C. Mischler |
| Hershey | Hershey | 717/534-8521 | * | W. P. Graham |
| Philadelphia | St. Agnes | 215/339-4333 | 11 | F. A. DeClement |
| | St. Christopher's for Children | 215/427-5000 | 4 | S. J. Hulnick |
| Pittsburgh | Mercy | 412/232-8225 | 7 | T. Layton |
| | Western Pennsylvania | 412/682-4200 | 14 | J. Gaisford |
| York | York | 717/771-2345 | 6 | J. Angelo<br>R. Davis |

[1]*American Burn Association*
* = *no designated area for burn care*

od. Results indicated that, in one-third of the transfers, at least one patient care procedure was altered by the transfer team, while the patient was being evaluated and stabilized at the referring institution.

Helicopter transfer of burn patients has developed recently in the western part of Pennsylvania under the auspices of Allegheny General Hospital's Life Flight Program. In its first year, ten percent of the program's 300 flights culminated in admissions to the Pittsburgh burn center. The Pennsylvania State Police also has six helicopters which can be diverted from their normal police functions to transfer patients to or between hospitals in medical emergencies.

The majority of thermally injured patients will continue to be transported to specialized facilities by land ambulance. Air transport is primarily cost-effective beyond a 40-mile radius, or during peak traffic periods when land ambulance transfers would be unduly delayed. Uneven road surfaces and stop-and-go traffic can also contribute to making air transfer the method of choice.

### Patient transfers

In burn care systems throughout the state, patients who have experienced thermal trauma first are transported to the nearest hospital emergency department for initial evaluation and stabilization. Physician evaluation determines whether a patient is to be transferred to a specialized burn facility. A wall chart providing guidelines for emergency departments, including burn center transfer criteria, has been mailed to each hospital emergency department in the Burn Foundation service area (see Table 2).

If a decision is made to refer a patient, the emergency department contacts the burn center and provides data on the patient. Depending on the patient's condition and available resources, a burn team consisting of a physician, nurse, and, where necessary, a respiratory therapist are dispatched to the referring hospital by land or air ambulance. The team evaluates the patient's status and makes adjustments in care procedures if necessary. When the patient is stabilized enough to travel, he is transferred to the burn center.

Burn centers, EHS Councils, and professional associations have sponsored frequent seminars on burn care in recent years throughout the state. Heavy participation by emergency department and ambulance squad personnel has led to significant improvements in both pre-hospital and emergency department burn care. Emergency room personnel have increased their skills in evaluating and stabilizing patients with thermal injury.

Although assessment of the burn injury itself is vital, burn physicians note that this must be carried out as part of a total patient evaluation, since other injury, notably internal trauma, may be overlooked. The skin injury may be impressive, but diagnosis and treatment of more immediate problems may be life-saving. Operations to correct such problems may be necessary before transferring a patient to a burn center.

It appears from a recently completed and as yet unpublished study of burn patient hospitalization in the state that judged by potential mortality, appropriate referral decisions generally are being made. A 96 percent sample of Pennsylvania burn hospitalizations in 1976-77, reviewed by the Burn Foundation of Greater Delaware Valley, revealed a burn patient mortality rate of less than 1 percent (60 deaths among 6,200 hospitalizations in two years) in the state's nonspecialized hospitals. Virtually all these deaths represented the only burn patient death at that particular hospital during the two-year period. The magnitude of burn injury, however, is difficult to assess in retrospective studies, since the size and depth of burn injury rarely are documented in discharge abstracts. This precludes assessment of mortality risk, let alone the less measurable potential for poor cosmetic and functional results.

### Team approach

The potential for poor results of this nature can be addressed most aggressively by a coordinated team approach

**TABLE 2**
**Assessment and Initial Care of Burn Patients**
***Guidelines for Hospital Emergency Departments***

1. **Stop burning process**
   Remove or cool hot clothing
   Extensive lavage of chemical burns
   Use mineral oil to remove adherent tar

2. **Maintain ventilation**
   Look for signs of inhalation injury (cough, singed nasal hair, soot, or edema in upper airway)
   - *Obstructed airway:*

   Hyperextend neck, suction, Endotracheal Tube
   - *Respiratory insufficiency:*

   Administer high concentration of oxygen until carbon monoxide is proven to be below toxic level
   Monitor ABG's
   Use Endotracheal Tube & Respirator if necessary

3. **Establish circulation**
   - *No pulse:* Administer CPR
   - *Pulse present:* Start I.V.

   Install I.V. line (#16 or #18 plastic cannula)
   Use Ringer's Lactate Without Glucose
   (2-4cc/kg Body Weight/% BSA burned)
   Objective: 30 to 50 cc urine/hr. in adults, 1 ml urine/kg/hr in children
   - *Burned extremity*

   Elevate, Remove Rings, Bracelets, etc.

4. **Maintain body temperature**
   Avoid systemic hypothermia or chill, using blankets if necessary

5. **History and physical**
   - Type, Area and Depth of Burn
   - Other Injuries (Fractures, CNS Trauma)
   - Details of Accident
   - Pre-existing Illness (e.g. Diabetes)
   - Use of Alcohol, Tobacco, Drugs
   - Allergies, Medications

6. **Assess ileus**
   Keep Patient N.P.O.
   Nasogastric Tube to drainage if there is nausea, vomiting or distention, or in burns over 25% BSA

7. **Relieve pain**
   Give narcotics, 2-4 mg. morphine or equivalent, I.V. only, to achieve desired effect (Restlessness may be from hypoxia)

8. **Treat burn wound**
   Cleanse gently with soap and water or saline
   Cool small (<10%) painful wounds
   Cover with clean sheet or burn dressing
   Maintain irrigation of eye wounds

9. **Tetanus prophylaxis**

10. **Consider admission to hospital**
    - Burn Size > 15% Body Surface Area 2°
      > 5% Body Surface Area 3°
      > 5% in Age < 5 or > 60
    - Critical Body Areas: Face, Hands, Feet
    - Inhalation Injury, Electrical Burn
    - Other Injuries or Pre-existing Illness
    - Limited Supervision Available at Home
    - Child Abuse Suspected

11. **Consider transfer to burn center**
    Transfer criteria should be modified according to judgment, interest and experience of attending physicians, and other burn care resources at the local hospital
    - Burn Size >20% children 0-10 yrs.
      >25% adults 10-60 yrs.
      >10% adults >60 yrs.
    - Deep Burns of Critical Areas
    - Inhalation Injury, Electrical Burns
    - Other Injuries, Pre-existing Illness

to burn care. The advances of recent years in both physical and occupational therapy, including new splinting techniques and the use of pressure garments to reduce scarring and contracture formation, have the greatest impact when patient compliance can be reinforced by several members of the burn team. The burn team is also important in stimulating the support of family and friends, a crucial ingredient to the patient's eventual recovery from both the physical and psychological impact of burn injury.

## Improvements

Despite these advances in providing burn center care, and the regionalization of care for the severely burned, improvements are needed in Pennsylvania. In assessing their own treatment capabilities, burn center directors strive to improve their $LA^{50}$, the level of severity measured in percent of body burned at which 50 percent of the patients in a given burn program can be expected to survive.

Centers in Pennsylvania which have applied this analysis to their burn caseloads compare favorably with the national average $LA^{50}$, which is about 52 percent. Significant progress beyond this level appears to require a breakthrough in treating severe respiratory injury, a major complication in most mortal outcomes of burn injury.

At the general hospital level, more prompt referral of patients potentially needing burn center care would improve overall outcomes and reduce lengths of stay. A recent study of 484 burn patient transfers to Saint Agnes Medical Center identified 15 percent as "delayed transfers" occurring more than 24 hours post-burn. There was no statistical difference between the delayed transfer and immediate transfer groups in age or percent of second degree or third degree burns, but the delayed transfer group had a significantly higher proportion of complications, a longer length of stay, and, in the group with 60-90 percent expected

mortality, a decrease in the survival rate.

**Burn prevention**

All those involved with burn inury would welcome progress in burn prevention, though significant breakthroughs are made difficult by the wide range of causes and sources of burn injury. Too often, such contributing factors as alcohol or drug abuse and the intent to cause injury to self or others further complicate burn prevention efforts.

Noting that such factors are not eliminated easily through educational efforts, most of those active in burn prevention feel that environmental intervention is a necessary part of any burn prevention program. An intervention measure currently receiving attention as a means of reducing burn injury is the self-extinguishing cigarette. Most cigarette-caused fires ignite only after a dropped cigarette has smoldered beyond the normal smoking interval. Such cigarettes, as promoted in legislation recently introduced in Congress, could reduce the death toll from careless use of smoking materials with little detriment to smoking enjoyment. This toll is estimated at 1,800 per year, or about 20 percent of the total national fire death toll. Several Pennsylvania legislators are cosponsoring the legislation.

Scald injury also is receiving increased attention, especially scalds occurring in baths and showers. Generally these are the most severe scalds but also the most easily prevented. Skyrocketing energy costs may accomplish as much as the most sophisticated safety education program. Homeowners who turn their hot water thermostats down to 120°F or below to reduce energy bills often are surprised at how much money is saved, with improved rather than reduced safety, and with negligible reduction in bathing and cleaning performance.

In Southeast Pennsylvania, the Health Systems Agency (successor to RCHP) has recognized prevention as an integral part of the burn system. HSA/SP has set a goal of a 5 percent reduction annually in the incidence of hospitalized burn injury in the burn care section of their Health Systems Plan. HSA staff and volunteer board members have taken the lead in promoting municipal ordinances requiring smoke detectors in all new residential construction throughout the area. As the state's other eight Health Systems Agencies gradually incorporate burn care sections into their regional plans, additional emphasis on prevention can be expected.

As a result, we can hope that the Commonwealth of Pennsylvania has experienced a peak in the need for specialized burn care facilities, and that we can anticipate a reduction in burn incidence in future years.

# TRAUMA

## Coordinated management of spinal cord injuries

**Edwards P. Schwentker, MD**
**Eileen M. Keegan, RN**
**Stephen R. Skinner, MD**

Injury to the spinal cord is the most serious, complex form of nonfatal trauma. No other type of injury has so significant an impact on the future of the survivor. Loss of spinal cord continuity disrupts normal function in every other organ system within the body. Management of the person with the cord injury requires the talents of virtually every clinical medical specialty and nearly every allied health discipline.

### Overview

The loss of voluntary motor function caudal to the injury robs the patient of mobility. Initially, this loss concerns the patient the most. The loss of urinary bladder control is more serious in terms of survival, however, for without a regular cycle of bladder emptying, urinary tract infection becomes inevitable.

Sensory loss is the second most serious threat to life, for anesthetic skin is prone to pressure ulceration and pressure sores may lead to sudden sepsis. Other effects include bowel incontinence, loss of sexual function, and disruption of the autonomic nervous system which, in turn, affects blood pressure regulation and internal temperature control.

The physiologic effects of spinal cord injury secondarily disrupt nearly every aspect of the patient's life, and as his life touches others close to him, their lives are radically altered. Financially, the impact reaches beyond the patient and family to society. In 1978, there were estimated to be 120,000 to 150,000 spinal cord injured individuals living in the United States.[1] The cost of care for these individuals exceeds $2.4 billion annually.

New injuries occur at a rate of approximately 11,000 per year. Eighty percent of these acute injuries involve adolescents and young adults between 15 and 30 years of age with an average age at the time of injury of 28 years. Lifetime costs per patient for simple maintenance of health and life will range from $180,000 to $400,000, depending on the level of injury. These figures do not include the loss of potential earning power suffered by those whose injuries have destroyed or downgraded their employability.

### History

Solutions to the complex problems of persons with spinal cord injury have gradually evolved. In World War I, mean survival following cord injury was only six to twelve months. By the start of World War II, mean survival was still only two to three years post-injury, but the large number of casualties with cord injuries which occurred in the war and their concentration within the Veteran's Administration hospitals led to a rapid development of improved methods of management.

Gradually, in the 1950s and 1960s, expertise spread to a number of civilian centers, and subsequent refinements in care have allowed survivals to approximate normal life spans, providing the patients are managed optimally from the time of injury. The medical technology now exists, but its adaptation throughout the country is inconsistent.

In June 1970, the Rehabilitation Services Administration of the Department of Health, Education, and Welfare awarded a research and demonstration grant to the Good Samaritan Hospital in Phoenix, Arizona to set up a model system for the comprehensive management of spinal cord injuries. Additional grants to other centers were awarded in the last decade, and there are now 14 federally-funded, model system centers throughout the United States. Each of these centers is part of a larger medical institution, but the spinal cord injury program is dedicated separately to spinal cord injury management. Data from the 14 centers are pooled, analyzed, and fed back to these centers.

The primary purpose of the model systems was to develop the principles and techniques for optimal management of the person with a spinal cord injury. The secondary purpose was to compare the results of treatment within the model system programs with the results of treatment outside the system. The study continues, but sufficient data have been collected and analyzed to establish unequivocally the value of the model system's approach in terms of decreased hospitalization, reduced incidence of complications, lowered costs, and improved success of rehabilitation.[2]

The mean length of hospitalization for a quadriplegic was 5.67 months, and for a paraplegic 4.22 months, using the model system's approach. Initial hospitalization costs, from injury to discharge from the rehabilitation hospital, averaged $39,600 for

*Dr. Schwentker is the director of the spinal cord injury team and an assistant professor in the orthopedic surgery division of the surgery department at The Pennsylvania State University College of Medicine, Hershey. Ms. Keegan is the coordinator nurse of the Spinal Cord Injury Program at Elizabethtown Hospital for Children and Youth. Dr. Skinner also is an assistant professor in the orthopedic surgery division at Hershey.*

quadriplegics and $27,600 for paraplegics. Although these figures are staggering, they represent significant reductions in hospitalization and cost when a coordinated approach to spinal cord injury is used.

### Coordinated program

The coordinated spinal cord injury program is divided into an acute phase, a rehabilitation phase, and a reintegration phase. It must be emphasized at the outset, however, that these phases are not distinct; in practice, they blend into one another. For example, the principles of rehabilitation begin to be applied on the day the patient first enters the program. The entire program directs itself toward the patient's successful rehabilitation and reintegration into his community. The program does not end with hospital discharge; continued follow-up and crisis intervention are vital to the maintenance of achievements.

### Acute phase

The acute phase of management of the patient with a spinal cord injury properly begins at the scene of the injury. Emergency medical technicians should be instructed in the appropriate techniques of handling and transport for a victim suspected of having a spinal cord injury. Ideally, patients should be transferred to a spinal cord injury center either from the scene or from other emergency care facilities as soon as they are medically stable. Detailed protocols should be available to facilitate transfers to the center and telephone consultation should be readily accessible to referring physicians.

On arrival at the emergency care unit of the spinal cord injury center, the patient should be met by the acute care team, usually including an emergency medicine physician, a neurosurgeon, an orthopedic surgeon, and a spinal cord injury nurse. The initial concerns are life support, prevention of further neurologic injury, assessment of the injury, and formation of a treatment plan. The goals of the acute phase are to stabilize the patient medically, to optimize potential neurologic recovery, and to promote spinal stability.

The spinal cord injury itself consists of two components: disruption of the structural continuity of the vertebral column, and damage to the neural contents of the spinal canal. The neural injury is clearly the most important; unfortunately however, it is frequently irreversible. The skeletal injury must not be ignored, for increasing or uncontrolled spinal instability may lead to further neurologic injury, pain, and deformity. It is imperative that the acute care team include both neurosurgeon and orthopedic surgeon, and that they work together.

The patient must be managed initially in a full service hospital equipped with diagnostic and treatment facilities that can handle not only injuries of the spinal cord, but also any form of major trauma, for frequently there are associated injuries involving other body systems. The hospital must be staffed adequately to provide a full range of medical and surgical services at all times.

Besides the immediate management of the spinal cord and vertebral injury, the treatment of the patient in the acute phase must emphasize the prevention of complications. An active program of prophylaxis is necessary to avoid numerous problems which would otherwise prolong hospitalization and increase morbidity and mortality. Preventing complications is one of the major reasons why patients should be transferred as soon after injury as possible to a coordinated spinal cord injury program.

Special expertise, especially in nursing management, is required to avoid pressure sores, urinary tract infection, bowel impaction, extremity contractures, and thrombophlebitis. When the vertebral column is unstable, spinal alignment must be maintained in all positions to avoid increasing neurologic deficit. Prophylaxis for gastric stress ulceration should be routine, and in patients with quadriplegia, close attention must be paid to respiratory function to guard against deterioration.

### Rehabilitation

The rehabilitation phase formally begins when the patient is medically stable and physically capable of participating in the active training program. The main principles of rehabilitation, however, begin in the acute phase. The patient is educated about his condition, and, throughout his entire course, is required to care for himself whenever possible. Therapeutic modalities are coordinated between the acute and rehabilitation phases to insure program continuity.

In the rehabilitation phase, the spinal cord injury team includes members from many allied health disciplines, such as physical therapists, occupational therapists, recreational therapists, orthotists, vocational counselors, psychologists, driving instructors, and nurses. Each team member has a special area of concern, but cooperation and communication are close, and interdisciplinary boundaries become indistinct. Everyone works toward common and well defined goals. All members of the rehabilitation team strive to maximize functional potential, prevent complications, and prepare the patient for maximum independence.

### Reintegration

Reintegration, the third phase of the coordinated program, begins early in the patient's hospitalization, overlapping in part both the acute and rehabilitation phases. The goal of reintegration is placing the patient back into the community in as independent a capacity as possible. Soon after his admission to the program, the patient's family and home community resources are assessed. If the patient is school age, his studies should be continued during his rehabilitation training then preparations made to return him to regular school. Adult patients should receive vocational counseling and, when necessary, contact should be made with the state Bureau of Vocational Rehabilitation for funding to assist in job retraining after discharge from the hospital.

Members of the rehabilitation team should visit the patient's home and recommend modifications to allow the patient maximum independence. Necessary modifications may include wheelchair ramps, widened doorways, or, in some cases, construction of an addition to an existing building structure.

As the patient masters self-care skills, short visits home (such as weekend leaves of absence) will allow him to apply his skills in the community and to assess for himself what

additional training he requires. After a leave of absence from the hospital, the patient may return with new challenges. As these challenges are met, repeated leaves of absence can allow application of new skills and identify new goals. Reintegration is a gradual process essential to success and particularly vital to the process of psychological readjustment.

The responsibilities of the coordinated spinal cord injury program to the patient and the community do not end when the patient is discharged from the rehabilitation hospital. By the time of discharge, the patient will have learned all that he can from within the institution, but he will have many lessons yet to learn from the outside world. The program must offer continued outpatient follow-up and the resources of crisis intervention to deal with the complications that inevitably will occur. With time, the patient's functional goals may change and the spinal cord injury team must maintain its availability to help the patient achieve these new goals.

## Prevention

The ultimate task of the coordinated program deals with preventing spinal cord injury. Data collected by coordinated programs about the causes of spinal cord injury can educate the community in accident prevention. This ability to generate such data based on large numbers of cases is one of the many advantages to coordinated spinal cord injury programs.

## Conclusion

Spinal cord injury is the most complex form of serious trauma and persons with spinal cord injuries require complex management. The studies founded by the Rehabilitation Services Administration through the Regional Model Spinal Cord Injury Systems have demonstrated unequivocally that a coordinated approach to the management of spinal cord injury patients, in a program dedicated to that effort alone, is the most effective and efficient alternative to achieving the goal of rehabilitation and reintegration in the community.

Unfortunately, many individuals with spinal cord injuries in Pennsylvania, as in the rest of the nation, are not treated with the coordinated approach. Acute care continues to be delivered at the scene of the crisis by professionals with little continuing experience. Rehabilitation often is delivered in a general rehabilitation program set up and staffed for a wide variety of patients, where the number of cord injury patients is low. Reintegration frequently is ignored altogether.

There are an estimated 11,000 spinal cord injuries occurring in the United States yearly, yet less than 1,800 individuals with spinal cord injuries are processed each year by State-Federal Rehabilitation Programs of which Pennsylvania's Bureau of Vocational Rehabilitation is a part. Despite the 14 federally-funded model systems and other independent, coordinated programs organized on the model system's concept in this country, only a minority of the patients appear successful in their vocational retraining.

Regionalization of emergency health care permits the concentration of patients to coincide with the concentration of experience. In no other category is regionalization more needed than in spinal cord injury care. To provide optimal treatment, each regional program must be dedicated to the management of persons with spinal cord injuries. To maintain the optimal level of experience, regional centers should be limited in number, allowing the centers to accumulate relatively large numbers of patients. Programs should be located close enough to the patient's home communities, however, to allow for the process of reintegration.

The Spinal Cord Injury Committee of the Pennsylvania Department of Health studied the management of this problem and reported in 1978 that Pennsylvania should have three to five spinal cord injury programs.[3] The principles have been established, tested, and proved. They need now to be put into practice by properly regionalizing spinal cord injury care for the entire Commonwealth.

## REFERENCES


1. **Thomas, J.P.:** Rehabilitation of the spinal cord injured: the model systems' approach. *Model Systems' SCI Digest 1*:3-6, 1979.
2. **Young, J.S., Northrop, N.E.:** Statistical information pertaining to some of the most common asked questions about SCI. *Model Systems' SCI Digest 1*:11-33, 1979.
3. A comprehensive plan for spinal cord injury services in Pennsylvania. Report of the Spinal Cord Injury Committee, Commonwealth of Pennsylvania Department of Health, PENNSYLVANIA MEDICINE *81* (5):29-54, 1978.

# TRAUMA

## Promise and problems of medical antishock trousers

**Jesse A. Weigel, MD**

History shows us that pioneering discoveries often come to fruition decades later. This is certainly true with the pneumatic antishock trousers. First described in the early 1900s by Dr. George Crile, the discovery of these trousers languished for a variety of reasons until recent recognition as an important modality in prehospital emergency medical care.

The Pennsylvania Emergency Health Services Council (PEHSC) recognizes that mortality and morbidity can be reduced by applying pneumatic antishock trousers (MAST), particularly in rural areas where advanced life support intervention may be delayed. The Council has recommended that MAST be used by basic life support personnel (EMTs) certified by the Pennsylvania Department of Health.

PEHSC serves as an advisory body to the Secretary of Health who, in turn, authorizes the Division of Emergency Health Services to implement programs. Medical literature shows that the MAST garment has few complications and proven advantages in the management of patients, particularly those with hypovolemic shock. Thus, the MAST program will begin to be implemented this fall in various regions of the Commonwealth.

### Using MAST garments

According to PEHSC, the most serious danger in using the MAST garment occurs when prehospital and emergency department personnel are not trained adequately and supervised in its use. It is, therefore, imperative that every physician, nurse, and EMT who may use MAST should understand how the device functions, what it can and cannot do, and what the body's physiological responses are to compression by the garment.

The initial thrust of training must be directed to physicians, nurses, and other hospital personnel who potentially may come in contact with the inflation and especially deflation of the MAST garment. From the limited experience we have had in Pennsylvania through EMT-Paramedic programs using this life-saving device, lack of appreciation and understanding of the garment by hospital personnel, in a few cases has resulted in catastrophic problems.

The mechanisms of action are well known and have been reported in the medical literature on numerous occasions. External compression on the lower part of the body transfers blood to vital organs in the upper torso (auto-transfusion of blood) and external pressure may control internal bleeding by tamponade. The device also can stabilize fractures of the pelvis and femur. Primarily, the MAST garment reduces hemorrhage and auto-transfuses the upper parts of the body, therefore allowing more time for transportation and surgical preparation.

### Indications for use

Systolic pressure below 80 mm Hg regardless of the cause, and a suspected fracture of the femur and the pelvis or systolic pressure below 80 mm Hg are the general indications for using the MAST garment. A fractured femur cannot be managed by any other pneumatic splints because they do not immobilize the joint above the fracture. With the MAST garment, the joint above, as well as the joint below the fracture, are immobilized. With regard to a fractured pelvis, not only is the pelvic fracture stabilized, but blood loss can be reduced significantly. The direct pressure of MAST also can reduce significantly hemorrhage in leaking abdominal aneurysm or traumatized bleeding organs such as the spleen, kidney, liver and others.

Today, the only contraindication to the use of the MAST garment is frank pulmonary edema. There have been other areas of controversy concerning such injuries and incidents as head trauma, intrathoracic injuries, congestive heart failure, and cardiac arrest.

### Application and removal

Application and inflation of the MAST garment have been depicted in the literature as well as in informational brochures issued by various companies that produce pneumatic antishock trousers. The Pennsylvania Emergency Health Services Council has established the protocol for the inflation procedure. According to PEHSC, direct verbal medical command after patient assessment has been performed by prehospital care personnel is necessary. This, in turn, requires an authorized physician capable of giving medical command.

Inflation of the garment can transfuse 1500 to 2000 ml of whole blood into the upper torso but deflation can perform a phlebotomy of the same volume. The deflation process is crucial. It must be done slowly, deliberately, and with close monitoring of the patient's blood pressure. To deflate properly, each segment of the garment should be deflated gradually beginning with the abdominal portion. As the air is allowed to escape, blood pressure should be monitored closely. When blood pressure remains stable, deflation proceeds in a slow, orderly fashion

*Dr. Weigel is director of the emergency department at Harrisburg Hospital and medical director of the division of Emergency Health Services, Pennsylvania Department of Health.*

The pitfall that must be avoided is inappropriate deflation of the device, which can produce more problems than any other aspect of its use.

Three-chambered MAST garments are recommended for use by prehospital emergency medical personnel.

with continued constant monitoring.

This stepwise method of gradual deflation with close monitoring of blood pressure will allow for gradual replacement of reduced blood volume and it gradually will accomplish recirculation to parts of the body which have had reduced circulation for a period of time.

There will be occasions when the blood loss is of such magnitude that the MAST garment cannot be deflated outside the operating room. In these situations, the patient is transported to the operating room where the operating team is ready. As the operation begins, deflation can occur and blood loss can be controlled.

### Implementing the program

The MAST garment must be integrated into Pennsylvania's prehospital care system in an orderly implementation process. The Division of Emergency Health Services of the Department of Health will develop the process and will promulgate it through the various regional emergency medical services projects statewide.

Implementation will include initial training of hospital personnel who will come in contact with the device, so that there is a clear and full understanding of the total mechanism, indications, and complications of this garment. Basic life support personnel (EMTs) will receive training and certification in formal classroom settings. Physicians and nurses will participate in instruction, and skills and knowledge examinations.

Using the MAST garment in the field presupposes radio communication systems that provide access to medical command by authorized, knowledgeable physicians. An evaluation process also is necessary for the regions and the state to assess the need for the use of the MAST garment, to examine the benefits it has for the citizens of the Commonwealth, and to maintain quality and appropriateness of application. The evaluation will include a standardized report form provided by the Division of Emergency Health Services.

### Conclusion

The MAST garment in the prehospital care setting has been demonstrated to be safe. Trained EMT and EMT-Paramedics can execute its application. When the device is used appropriately, patients arrive in emergency departments or operating rooms stabilized and in better condition than without its use.

Inappropriate deflation of the device can produce more problems than any other aspect of its use. Only through a program including initial training of inhospital personnel, development of adequate communication systems, training of basic life support personnel in the field, and development of a data and evaluation mechanism, can the use of the MAST garment within the Commonwealth of Pennsylvania improve the effectiveness of prehospital emergency health care.

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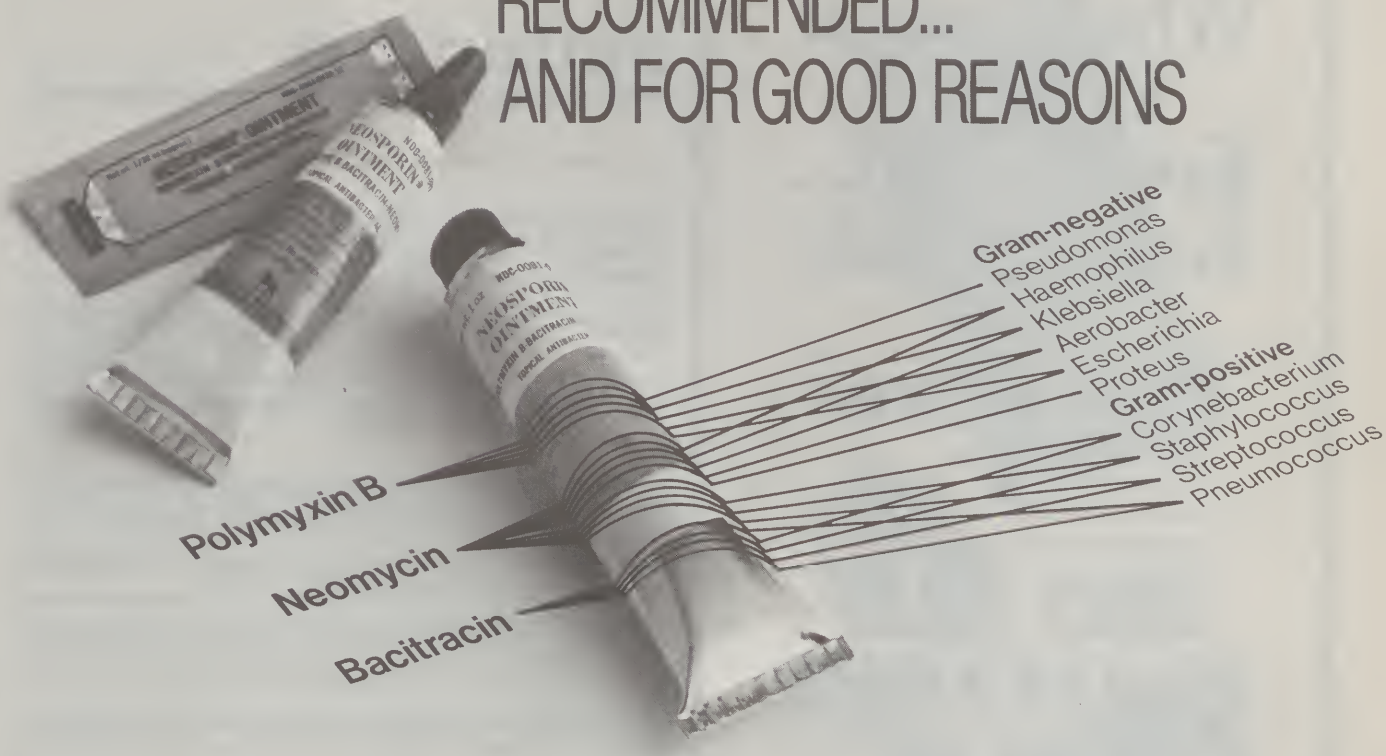


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# obituaries

• *Indicates PMS membership at time of death*

• **Vikram D. Amin,** North Charleroi; Mysore University, India, 1968; age 36, died July 2, 1980. Dr. Amin was on the staff at Canonsburg General and Mon Valley hospitals.

• **Joseph L. Barthold,** Norristown; Jefferson Medical College, 1932; age 74, died June 24, 1980. Dr. Barthold was a family practitioner in Norristown from 1933 until his retirement in 1979. He was a staff member of Montgomery Hospital and a courtesy staff member of Sacred Heart Hospital.

• **William Patrick Coghlan,** Beaver Falls; Jefferson Medical College, 1947; age 57, died July 6, 1980. Dr. Coghlan, a general and thoracic surgeon, was honored by the board of directors of the Medical Center of Beaver County who dedicated the educational and research center of the new facility to him.

• **Solkin C. Copeland,** Merion; University of Pennsylvania School of Medicine, 1927; age 77, died June 18, 1980.

• **Jacob Antrim Crellin,** Newtown Square; Hahnemann Medical College, 1925; age 81, died June 19, 1980.

• **Mitchell L. Dratman,** Philadelphia; Hahnemann Medical College, 1943; age 63, died June 17, 1980.

• **William Julius Ezickson,** Broomall; Medico College, 1915; age 88, died July 11, 1980. Dr. Ezickson, a urologist in center city Philadelphia for 50 years, had been professor of urology at the Graduate School of Medicine of the University of Pennsylvania. He also was a staff physician at Graduate, St. Joseph's, and Pennsylvania hospitals.

• **William Thomas Fitts, Jr.,** Philadelphia; University of Pennsylvania School of Medicine, 1940; age 75, died June 17, 1980. Dr. Fitts, professor of surgery at the University of Pennsylvania School of Medicine, was internationally recognized for his contributions to the surgical treatment of trauma. He was a former chief of surgery at the Hospital of the University of Pennsylvania, a former editor of the *Journal of Trauma,* and a past president of the American Association for the Surgery of Trauma.

• **Richard K. Frawley,** Titusville; University of Pittsburgh School of Medicine, 1933; age 73, died June 16, 1980. Dr. Frawley practiced in Titusville for 36 years and was on the staff of Titusville Hospital.

• **Karl William Hahn,** Bethlehem; Jefferson Medical College, 1929; age 79, died June 18, 1980. Dr. Hahn had been a general practitioner in Bethlehem since 1932.

• **George W. Hanna,** Indiana; Georgetown University School of Medicine, 1938; age 73, died June 23, 1980. Dr. Hanna was a former chief of surgery at Indiana Hospital.

• **Kenneth H. Hinderer,** Pittsburgh; University of Pittsburgh School of Medicine, 1930; age 76, died July 6, 1980.

• **R. Wallace Journey,** Chester; University of Pennsylvania

School of Medicine, 1953; age 59, died June 25, 1980. Dr. Journey delivered more than 6,000 children in his 20 years as an obstetrician and gynecologist in Chester. He had been chief of obstetrics and gynecology at Taylor Hospital for 10 years and was on the staffs of Riddle and Sacred Heart hospitals and Crozer-Chester Medical Center.

• **Irwin Leonard Kaufman,** Pittsburgh; Jefferson Medical College, 1935; age 69, died June 24, 1980.

• **Armas Samuel Kyllonen,** Pittsburgh; Boston University School of Medicine, 1944; age 62, died July 14, 1980.

• **Frank B. Lynch, Jr.,** Philadelphia; University of Pennsylvania School of Medicine, 1913; age 91, died July 2, 1980. Dr. Lynch had been an instructor and researcher in bacteriology and pathology at the University of Pennsylvania for more than 30 years. He was emeritus founding fellow of the College of American Pathologists.

• **Khalil Maghen,** Philadelphia; Iran Medical School, Tehran; age 47, died June 16, 1980.

• **Francis T. McGinnis,** Drexel Hill; University of Pennsylvania School of Medicine, 1931; age 75, died June 20, 1980.

• **Carleton C. Richards,** Philadelphia; Howard University College of Medicine, 1939; age 68, died July 15, 1980. Dr. Richards had a family practice in South Philadelphia for 40 years. He was executive secretary and national treasurer of the National Medical Association. In 1979 he received its Charles R. Drew Achievement Award.

• **Abraham L. Schaller,** Philadelphia; Temple University School of Medicine, 1913; age 91, died July 11, 1980. Dr. Schaller had been a family physician in general practice in Philadelphia for 67 years.

• **Earlin J. Stahler,** Allentown; University of Maryland School of Medicine, 1949; age 57, died June 29, 1980. Dr. Stahler was a former chief of general surgery at the Allentown and Sacred Heart Hospital Center and chairman of the surgery department at Allentown Hospital. He had practiced general surgery in Allentown for 25 years.

• **Francis J. Trunzo,** Punxsutawney; Hahnemann Medical College, 1934, age 75, died June 15, 1980. Dr. Trunzo was secretary treasurer and medical director of the medical staff of Punxsutawney Area Hospital.

**Gilbert Eugene Fisher,** Wellsville; University of Michigan School of Medicine, 1936; age 71, died July 2, 1980. Dr. Fisher was a former medical missionary to Thailand. He returned from Thailand in 1972 and became a consultant in an ear, nose, and throat practice in Wellsville.

**John Edward Flanagan,** Erie; University of Buffalo School of Medicine, 1966; age 44, died June 12, 1980. Dr. Flanagan was chief of the nephrology division and director of the renal dialysis unit of Hamot Medical Center.

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# physicians in the news

**Harry C. Stamey, MD,** senior vice president and medical director at Geisinger Medical Center since 1973, has been named president of the American Academy of Medical Directors. He was installed as president during the society's recent annual meeting in White Sulphur Springs, West Virginia.

The 45th president of the College of Physicians of Philadelphia is **Lewis W. Bluemle, Jr., MD,** president of Thomas Jefferson University. Elected with Dr. Bluemle were **Drs. Brooke Roberts,** vice president; **George L. Spaeth,** secretary; **John H. Hodges,** treasurer; and **Herman Beerman,** honorary librarian.

**Theodore R. Koenig, MD,** recently was honored at a dinner sponsored by the Knox Rotary Club and Dr. Iseli Koenig Krauss. The dinner celebrated Dr. Koenig's 50 years of medical practice and 48 years of service as a physician in the Knox community.

The family practice and community health department of Temple University School of Medicine recently presented its "Preceptor of the Year" award to Phoenixville Medical Associates, Ltd. Members of the group include **Drs. Matthew B. Naegle, Joel W. Eisner, Thomas C. Michaelson, Paul H. Rogers,** and **John F. Freehafer.**

Hospice Saint John, a division of Lutheran Welfare Service of Northeastern Pennsylvania, Inc., has named **Stephen E. Haley, MD,** medical director for its program of care for terminally ill patients and their families. He is adjunct professor of clinical medicine in the department of allied health of King's College and also teaches at Hahnemann Medical College and Hospital.

The American Academy of Neurological and Orthopedic Surgeons has selected **William J. Mitchell, MD,** Uniontown orthopedic surgeon, as national director of its newly formed kinesiology department. He is vice president of the Tri-State Orthopedic Society, a group representing Pennsylvania, Maryland, and West Virginia.

**Albert J. Stunkard, MD,** professor of psychiatry at the University of Pennsylvania School of Medicine, recently was honored with three awards. He received the William C. Menninger Memorial Award from the American College of Physicians at its April convention for his contributions to the science of mental health. He also recieved the Foundations Fund Prize of the American Psychiatric Association for research in psychiatry. His third honor is his recent induction into the Society of Scholars of Johns Hopkins University.

**Walter J. Okunski, MD,** and **Peter E. Farrell, MD,** recently were elected new members of the Allentown and Sacred Heart Hospital Center's board of directors. Dr. Okunski, an Allentown plastic surgeon and director of the ASH Burn Center, also was elected president elect of the medical staff for 1980-82. Dr. Farrell, an Allentown ear, nose, and throat specialist and member of the Sacred Heart Hospital board of directors, is the incoming president of the Sacred Heart medical staff.

**Stewart G. Wolf, Jr., MD,** has been named chairman of the scientific advisory committee of the Muscular Dystrophy Association. He is vice president for medical affairs at St. Luke's Hospital, Easton.

**William H. Rogers, MD,** recently was elected to the International Cardio-vascular Society. He is chief of surgery at Pocono Hospital, East Stroudsburg.

**John Persing, MD,** Lewisburg, is the new president of the American Heart Association, Northcentral Pennsylvania Chapter, Inc. Other officers are **Drs. Donald Bowes,** Danville, president elect; and **Lynn A. Smaha,** Sayre, vice president. **S. William Snover, MD,** and **Lynn A. Smaha, MD,** were recognized as outstanding volunteers.

Union County Medical Society recently presented **J. Preston Hoyle, MD,** with its Physician of the Year Award.

**Irving Williams, III, MD,** secretary of the society, presented the award in recognition of Dr. Hoyle's "outstanding contributions and dedication to organized medicine." Dr. Williams noted in his presentation that the award last was given to the late **Amos V. Persing, MD,** of Watsontown.

Dr. Hoyle has served on the Union County Medical Society Executive Committee, as president in 1969, and as secretary from 1973 to 1978. He has been a delegate to the PMS House of Delegates from 1969 through 1980.

Since 1960 he has been a member of PMS. The Council on Governmental Relations and the Committee on Impaired Physicians are two areas where he has contributed to organized medicine in 1979 and 1980.

In the political arena, he has been a member of the board of directors of the Pennsylvania Medical Political Action Committee since 1974. He was its vice chairman in 1978 and for the past two years has served as chairman of PaMPAC.

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# Milestone 25 jogs memory, recalls changes

**John F. Rineman**
**Executive Vice President**

Anniversaries are not just dates on the calendar. They are also milestones which measure out the course of our life or career, and the approach of each new one compels us to pause and recollect the landscape we have passed.

Nor are anniversaries just personal events. It's a rare person who travels down any road alone—without joining or being joined by others along the way. Remembrances of these others are very much a part of anniversary recollections.

As I pause at a special milestone in my career with the Pennsylvania Medical Society—the twenty-fifth—I would like to share with you my thoughts as I think back over the road traveled for 25 years.

## Early days

I remember having all of the trepidations of a new employe as I entered on April 1, 1955, the state headquarters in downtown Harrisburg of what was then called the Medical Society of the State of Pennsylvania.

I was to be a staff assistant in the department of public relations. I brought to this job the relevant experience of a degree in radio and television from Boston University and three years as sports announcer for WLAN radio in Lancaster. I also had the irrelevant experience of an undistinguished career selling insurance.

Lester Perry was executive director of the Society then, but my immediate supervisor was William B. Harlan, then director of public relations and now executive director of the Dauphin County Medical Society. My job was to act as liaison with radio and television stations throughout the state and to produce and promote an extensive public relations campaign undertaken by the Society, "Safeguard Your Health."

Older members may remember this campaign, and perhaps were a part of the radio and TV appearances that it involved. Besides developing topics and scripts for the programs, I traveled the state meeting with radio and TV people.

When I joined the Society, the late Robert L. Schaeffer, MD, from Lehigh County, was elected president, but my first real working relationship with a physician member was with the late John F. Hartman, Jr., MD, of Erie. In those days, the Society's concerns were divided among many, many committees and commissions, and these were further divided into sub-committees and commissions. Dr. Hartman was responsible for the Subcommittee on Radio and Television within the Committee on Public Relations.

Within the first few days of my employment, I went to Dr. Hartman's room at the now defunct Harrisburger Hotel to discuss radio and TV plans prior to a committee meeting. Needless to say, I was nervous. But I was quickly put at ease when early in our conversation he said, "If we're to work together, you're going to have to call me Jack."

Another early memory is of attending my first House of Delegates session, held that year in Pittsburgh. I was struck by the decorum and order that characterized the discussions of issues. This, of course, continues into the present. I think that anyone who wants to study how an ideal deliberative body works would do well to observe the operations of the PMS House.

One of the voices I remember from my earliest annual meetings was that of a Pittsburgh physician who talked about something called "Utilization Review." I am referring, of course, to Matthew Marshall, Jr., MD, the Society's current president.

From this came the "Marshall Plan" for setting up committees of doctors for the purpose of conducting something called "peer review." From that initiative has sprung a tradition of leadership in peer review which has been recognized across the nation. Along the way spinoffs have included the Hospital Utilization Project (HUP) of Pittsburgh and the PSRO support center, whose staff taught the principles of peer review to other PSROs across the country.

## Battling the bureaucracy

It doesn't require a strong memory to recognize that lobbying and government relations have changed over the past 25 years. In the '50s and

perhaps until the late '60s or early '70s, legislative staffs were all but nonexistent. Consequently, house members and senators depended heavily on special interest groups like PMS as sources of information. I might add, that as I look back, I cannot find any instance where they were served badly by these sources.

Over the last decade the proliferation of a host of special interests, many of whose goals run counter to ours, has made PMS lobbying efforts more intense and more important as a Society mission.

I recognize less change in our relationship with the executive branch of state government. Our relationship with the secretary of health, from my earliest days when the late Charles L. Wilbar, Jr., MD, held the post, to the present, has remained as frank as it has been cordial.

Our relationship with what was formerly the Department of Public Assistance and is now the Department of Public Welfare has also maintained a familiar consistency over the years. What is now called medicaid was once called medical assistance, and under both names, the Society has been forced to pursue vigorous efforts in an attempt to get an appropriate fee schedule for state physicians.

Most recently, we have seen government bureaus attempt to govern by regulations in the absence of legislative direction or sometimes even contrary to the legislature's intent.

In the case of laboratory regulations, we had to sue the Department of Health when its regulations exceeded the intent of the legislature. Although we lost that case in the Supreme Court, we won our case against the Welfare Department when it tried to practice medicine without a license. The specific issue was the Department's proposed ban on payment for most benzodiazepines.

A slightly different problem occurred with the Department of State in 1978 when PMS had to sue the Commonwealth again, this time to pry loose the money earmarked for the State Board of Medical Education and Licensure.

Over the last decade an increasing amount of Society time and money has been devoted to these battles with the bureaucracy.

**Reorganization of society**

I moved out of the Public Relations Department to become executive assistant, and subsequently, assistant executive vice president with various new duties. At the same time, a subtle, but substantial change was occurring at PMS.

During the early 1960s, the Society attempted to strengthen its public relations effort and its ability to deal with socioeconomic issues, which were becoming more important daily. To meet these needs, the Society employed two consulting firms but their success was only moderate. The major outcome of these attempts was that the Society recognized the demands to develop a staff skilled in the many aspects of organized medicine that we are so familiar with today.

A few years earlier, the Committee to Study Committees and Commissions studied the Society's organization and recommended the Society be reorganized by councils. These two changes, a more highly specialized and skilled staff and an organization constituted by councils, in my mind signaled the beginning of the modern era at PMS. It made the Society both more responsive to physicians' needs and, at the same time, more capable of responding.

This reorganization and increased staff capability enabled the Society to confront the issues that arose in the '60s and '70s.

The beginning of the '60s saw the formation of PaMPAC, the Society's political action committee. It responded to the activities of other interest groups and actually preceded the formation of AMPAC by the American Medical Association.

As specialty societies became stronger, we phased out the scientific meetings at annual session, and instituted the Continuing Education Requirement.

In 1975 we encountered the malpractice insurance crisis, a multifaceted problem which has remained a major Society concern ever since.

By the close of the '70s the Society was involved in its first challenge by

**John F. Rineman receives the ceremonial gavel of the American Association of Medical Society Executives (AAMSE) from Hart F. Page, outgoing president of AAMSE and chief executive officer of the Ohio State Medical Association. Rineman was installed as president at the association's annual meeting, July 19, 1980 in Chicago.**

the FTC in the commission's investigation of alleged physician control of Blue Shield. The litigious forces rampant in America generally in the '70s were also felt at PMS. For the first time in its history, the Society sued and was sued, not just once but numerous times. The Society has been compelled to anticipate the legal ramifications of its activities, and daily communications with legal counsel have become almost routine.

As I look back over my 25 years with PMS, I am impressed with the way PMS has adapted to change. Without question, the issues facing organized medicine have become more complex, and the Society's structure has had to become more formalized to deal with these. In my early days with the Society, the Board did not have an executive committee, nor were there reasons for having one. The complexity of issues and their fast-breaking nature has changed us. For instance, during the last decade it has even been necessary for the Society to call special sessions of the House of Delegates.

At the same time, the politics of the Society have become much more open. It is my impression, and I think an accurate one, that the Society in my earlier days was more tightly controlled by a few. The sort of "democratization" of the modern era of PMS represents a trend that has occurred throughout society in America.

### Highlights

If I were to point to the highlights of my career with PMS, I think I would choose my selection as executive vice president, the formation of PMSLIC, and the current building expansion.

I'll never forget the calculated casualness with which I was told of my appointment as executive vice president. My notice of the appointment came at the end of a board meeting in May 1968.

William A. Limberger, MD, from Chester County, then chairman of the board, came up to me just as the post-board meeting reception was starting and said, "Let's get a drink, I want to talk to you." And then he told me that the board had selected me to succeed Les Perry. This, needless to say, has been my proudest personal moment.

The formation of PMSLIC was another proud moment, but of a different kind. PMSLIC was created at a time of severe crisis and was put together in just 70 days. No other effort in my memory at PMS better demonstrated the ability of the Society's policymakers and its administrative staff to respond to events and to respond with a supreme degree of effectiveness.

I think the Society as a whole, can look to our current headquarters expansion with a sense of achievement. It represents the natural and logical growth of the Society's mission to serve its members. When finished in the late spring of 1981, it will house the staff of PMSLIC and provide additional meeting rooms and office space for the Society's ongoing activities.

No recollection of my years at PMS would be complete without recognition—nay, praise—for the staff members I have served with and continue to serve with—those who have traveled with me these 25 years. The board of trustees has continually demonstrated its faith in the administration of the Society by not involving itself in the day-to-day staff operations of PMS. That the Society has maintained an efficient, economical, and effective operation is a testimony to its staff and to the physician members for whom we work.

The skill with which PMS operates on a daily basis was brought home to me in a somewhat ego-deflating, yet positive manner, in 1973 when I was ill and out of the office for an extended period. As I called each day to find out what was going on that might require my attention, on most occasions I was told, "Everything is operating smoothly."

Yes, as I think back on my 25 years at PMS, my recollections are joyful ones, filled with memories of hard work and a minimum of disappointments. This joy increases with the anticipation of greater challenges and even better recollections in the future.

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# New JCAH standard emphasizes results, reviews

**John E. Affeldt, MD**

PENNSYLVANIA MEDICINE invited Dr. Affeldt to write this article after an exchange of letters between him and PMS President Matthew Marshall, Jr., MD, revealed a need for discussion of the standard.

The JCAH has always recognized the vital role that physicians play in providing health care within U.S. hospitals. Indeed, JCAH standards clearly state that the hospital's medical staff has overall responsibility for the quality of medical care provided to patients and for the ethical conduct and practices of its members.

**New standard**

The new JCAH's quality assurance standard provides guidelines for the overall review and evaluation of medical staff care and practice. The standard also encourages more appropriate use of physicians' time and hospital resources, emphasizes innovation in the use of evaluation methodologies, and provides a framework within which physicians can use a variety of mechanisms to establish and maintain a comprehensive, integrated quality assurance program.

The quality assurance standard, which becomes effective for accreditation decision purposes on January 1, 1981, reflects the JCAH's belief that an integrated, problem-focused approach to quality assurance activities will improve the quality of care provided in hospitals and the use of resources to evaluate that care. The primary aim of the standard is to shift emphasis from methods to results and from diagnosis-specific audits to hospital-wide, problem-focused reviews that build on current activities and strengthen the coordination and integration of overall quality assurance activities.

In many cases, the coordination and integration of quality assurance activities throughout the hospital should result in a streamlining and realigning of committee responsibilities, which should not only minimize demands on physicians' time, but use their time more efficiently. Physicians' time is used best, and the interests of quality assurance are served best, when hospitals and physicians streamline and improve existing mechanisms to identify and resolve known or suspected problems that may have an impact on patient care.

When the JCAH adopted the standard in April 1979, and eliminated the quantitative requirements for audit, it did not abrogate the importance of audit as a part of a quality assurance program. To the contrary, JCAH believes that a well-performed audit can focus effectively on an identified problem and can lead to improving patient care and clinical performance.

Traditional medical audit, without the quantitative requirements, remains a recognized and useful assessment tool that can be coordinated with other appraisal tools and used to solve identified problems in patient care. By giving physicians more flexibility in selecting and identifying problem areas and in performing studies in these areas, JCAH believes that both the study process and the study results will have greater impact on patient care.

During the development of the standard, JCAH staff interviewed members of medical staffs, administrators, nurses, medical record personnel, and quality assurance personnel to determine whether the costs of establishing and maintaining a quality assurance program such as that required by the new standard would increase overall expenditures for such activities. Those who could determine the cost concluded that the long-term benefits of an integrated program might decrease the costs associated with quality assurance.

Their projections of decreased costs would be realized particularly if the hospital modified current audit activities and if the responsibility for quality assurance were delegated to an existing committee or individual currently responsible for quality assurance activities. In addition, those interviewed believed that the problem-focused approach to quality assurance required by the standard would enhance the hospital's ability to provide the most improvement in patient care for the money invested in the assessment of that care. Because the standard requires that the quality assessment activities be integrated and coordinated, a program based on the standard also may decrease the cost of professional liability insurance coverage and funds expended in claims resolution.

**Comment**

The JCAH quality assurance standard has been made flexible enough to permit physicians to choose the method of evaluation most appropriate to the problem. This flexibility also allows for quality assessment activities to be coordinated into a single program that is time-efficient and cost-effective. The standard encourages the use of all current quality assessment activities and committees and any methodologies, such as audit, that are established in the hospital.

The standard also can accommodate any advances in the state of the art of evaluation or in the state of the art of medical care. The JCAH believes that the new quality assurance standard provides medical staffs with a more realistic, flexible, and comprehensive framework within which to fulfill their overall responsibility for the quality of medical care provided to patients. □

*Dr. Affeldt is president of the Joint Commission on Accreditation of Hospitals in Chicago, Illinois.*

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*Topics*

Women, Change, and Society • Roots and Consequences of Male Ambivalence to Women • The Women's Movement and the Psychotherapy of Men • Women and Hysteria • Professional Success—A Conflict for Women to Surpass • Women in Marital and Maternal Roles • Unconscious Assumptions Affecting the Psychotherapy of Women • An Anthropological Examination of Culture, Society, and Women's Roles—Implications for Mental Health • Women and Depression

Registration fee $125 (including two luncheons and Thursday evening dinner at the Philadelphia Marriott). Conference will provide 12 hours of Category 1 credit. The program is co-sponsored by Hahnemann Medical College. Mrs. Mary Foley, Conference Registrar, Friends Hospital, Roosevelt Blvd. at Adams Ave., Phila. PA 19124; (215) 831-4601.

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†**Perioperatively:** Two grams administered intravenously or intramuscularly just prior to surgery (approximately ½ to 1 hour before the initial incision); then 2 grams every 6 hours for no more than 24 hours.

‡**Cesarean-section patients:** The first dose of 2 grams is administered intravenously as soon as the umbilical cord is clamped. The second and third doses should be given as 2 grams intravenously or intramuscularly 4 hours and 8 hours after the first dose. Subsequent doses may be given every 6 hours for no more than 24 hours.

For complete details on dosage and administration, see full prescribing information.

If there are signs of infection, specimens for culture should be obtained for the identification of the causative organisms so that appropriate therapy may be instituted.

MEFOXIN (Cefoxitin Sodium, MSD) is contraindicated in patients who have shown hypersensitivity to cefoxitin and the cephalosporin group of antibiotics. Before therapy with MEFOXIN is instituted, careful inquiry should be made to determine whether the patient has had previous hypersensitivity reactions to cefoxitin, cephalosporins, penicillins, or other drugs. This product should be given with caution to penicillin-sensitive patients. Antibiotics should be administered with caution to any patient who has demonstrated some form of allergy, particularly to drugs. If an allergic reaction to MEFOXIN occurs, discontinue the drug. Serious hypersensitivity reactions may require epinephrine and other emergency measures. Use of the drug in women of childbearing potential requires that the anticipated benefit be weighed against the possible risks.

**For a brief summary of prescribing information, please see following page.**

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**Indications and Usage:** *Treatment*— Serious infections caused by susceptible strains of the designated microorganisms in the following diseases:
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GENITOURINARY INFECTIONS. Urinary tract infections caused by *E. coli, Klebsiella* species, *Proteus mirabilis,* indole-positive *Proteus* (i.e., *P. morganii, P. rettgeri,* and *P. vulgaris*), and *Providencia* species. Uncomplicated gonorrhea due to *Neisseria gonorrhoeae.*
INTRA-ABDOMINAL INFECTIONS, including peritonitis and intra-abdominal abscess, caused by *E. coli, Klebsiella* species, *Bacteroides* species including the *B. fragilis* group,‡ and *Clostridium* species.
GYNECOLOGICAL INFECTIONS, including endometritis, pelvic cellulitis, and pelvic inflammatory disease, caused by *E. coli, N. gonorrhoeae, Bacteroides* species including the *B. fragilis* group,‡ *Clostridium* species, *Peptococcus* species, *Peptostreptococcus* species, and group B streptococci.
SEPTICEMIA caused by *Strep. pneumoniae* (formerly *D. pneumoniae*), *Staph. aureus* (penicillinase and non-penicillinase producing), *E. coli, Klebsiella* species, and *Bacteroides* species including the *B. fragilis* group.‡
BONE AND JOINT INFECTIONS caused by *Staph. aureus* (penicillinase and non-penicillinase producing).
SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph. aureus* (penicillinase and non-penicillinase producing), *Staph. epidermidis,* streptococci (excluding enterococci, e.g., *Strep. faecalis*), *E. coli, P. mirabilis, Klebsiella* species, *Bacteroides* species including the *B. fragilis* group,‡ *Clostridium* species, *Peptococcus* species, and *Peptostreptococcus* species.
Although appropriate culture and susceptibility studies should be performed, therapy may be started while awaiting these results. Cefoxitin is not active *in vitro* against most strains of *Pseudomonas aeruginosa* and enterococci (e.g., *Strep. faecalis*) and many strains of *Enterobacter cloacae.* Methicillin-resistant staphylococci are almost uniformly resistant to cefoxitin.
***Prevention***— Prophylactic use perioperatively (preoperatively, intraoperatively, and postoperatively) in surgical procedures (e.g., vaginal hysterectomy, gastrointestinal surgery) classified as contaminated or potentially contaminated or in patients in whom infection at the operative site would present a serious risk, e.g., prosthetic arthroplasty; intraoperatively (after umbilical cord is clamped) and postoperatively in cesarean section.
MEFOXIN usually should be given ½ to 1 hour before the operation, which is sufficient time to achieve effective levels in the wound during the procedure. Prophylactic administration should usually be stopped within 24 hours since continuing administration of any antibiotic increases the possibility of adverse reactions but, in the majority of surgical procedures, does not reduce the incidence of subsequent infection. However, in patients undergoing prosthetic arthroplasty, it is recommended that MEFOXIN be continued for 72 hours after the surgical procedure. If there are signs of infection, specimens for culture should be obtained for the identification of the causative organism so that appropriate therapy may be instituted.
**Contraindications:** Previous hypersensitivity to cefoxitin and the cephalosporin group of antibiotics.
**Warnings:** BEFORE THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE PREVIOUS HYPERSENSITIVITY REACTIONS TO CEFOXITIN, CEPHALOSPORINS, PENICILLINS, OR OTHER DRUGS. GIVE WITH CAUTION TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. IF AN ALLERGIC REACTION TO CEFOXITIN OCCURS, DISCONTINUE THE DRUG. SERIOUS HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.
**Precautions:** The total daily dose should be reduced in patients with transient or persistent reduction of urinary output due to renal insufficiency because high and prolonged serum antibiotic concentrations can occur in such individuals from usual doses. As with other antibiotics, prolonged use may result in overgrowth of nonsusceptible organisms; repeated evaluation of the patient's condition is essential. If superinfection occurs, take appropriate measures. Increased nephrotoxicity has been reported following concomitant administration of cephalosporins and aminoglycoside antibiotics.
*Interference with Laboratory Tests*— As with cephalothin, high concentrations (>100 mcg/ml) may interfere with measurement of serum and urine creatinine levels by the Jaffé reaction and produce false increases of modest degree in creatinine levels reported; serum samples should not be analyzed for creatinine if withdrawn within 2 hours of cefoxitin administration. A false-positive reaction for glucose in urine has been observed with CLINITEST§ reagent tablets.
*Pregnancy*— In women of childbearing potential, weigh anticipated benefit against possible risks.
*Nursing Mothers*— Cefoxitin is excreted in human milk in low concentrations.
*Infants and Children*— Safety and efficacy in infants from birth to three months have not yet been established. In children three months and older, higher doses have been associated with increased incidence of eosinophilia and elevated SGOT.
**Adverse Reactions:** The most common adverse reactions have been local reactions following intravenous or intramuscular injection. Other adverse reactions have been encountered infrequently. *Local Reactions*— Thrombophlebitis with intravenous administration; pain, induration, and tenderness after intramuscular injections. *Allergic Reactions*— Rash, pruritus, eosinophilia, fever, and other allergic reactions. *Gastrointestinal*— Nausea, vomiting, and diarrhea. *Blood*— Transient eosinophilia, leukopenia, neutropenia, and hemolytic anemia; a positive direct Coombs test may develop in some individuals, especially those with azotemia. *Liver Function*— Transient elevations in SGOT, SGPT, serum LDH, and serum alkaline phosphatase. *Renal Function*— Elevations in serum creatinine and/or blood urea nitrogen levels.
**Note:** In group A beta-hemolytic streptococcal infections, therapy should be maintained for at least 10 days to guard against the risk of rheumatic fever or glomerulonephritis. In staphylococcal and other infections involving a collection of pus, surgical drainage should be carried out where indicated. Intramuscular injections should be well within the body of a relatively large muscle such as the upper outer quadrant of the buttock (i.e., gluteus maximus); aspiration is necessary to avoid inadvertent injection into a blood vessel. The total daily dosage in infants and children should not exceed 12 grams.
**How Supplied:** Sterile cefoxitin sodium in vials and infusion bottles containing 1 gram or 2 grams cefoxitin equivalent.

*For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486*

MSD
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‡*B. fragilis, B. distasonis, B. ovatus, B. thetaiotaomicron, B. vulgatus*
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1:30 "Electrocoagulation in Ulcers and 'Itis' " — John Papp, MD
1:45 "Colonoscopic Bleeding Control" — Bergen Overholt, MD
2:00 Panel
Moderator: William Mahood MD
Worth Boyce, MD — Bergen Overholt MD
Dave Falkenstein, MD — John Papp, MD
3:00 Coffee, Coke and Danish

**II. *OPERATIVE ENDOSCOPY* 3:30 - 5:30 p.m.**

3:30 "Insertion of Esophageal Prosthesis - Technique and Results" — Worth Boyce, MD
3:45 "UGI Polypectomy and Bezoar Removal" — John Papp, MD
4:00 "Operative Endoscopy in and around the Papilla of Vater" — Dave Falkenstein, MD
4:15 "Complicated Colonic Polypectomy" — Bergen Overholt, MD
4:30 Panel
Moderator: Norman N. Cohen, MD
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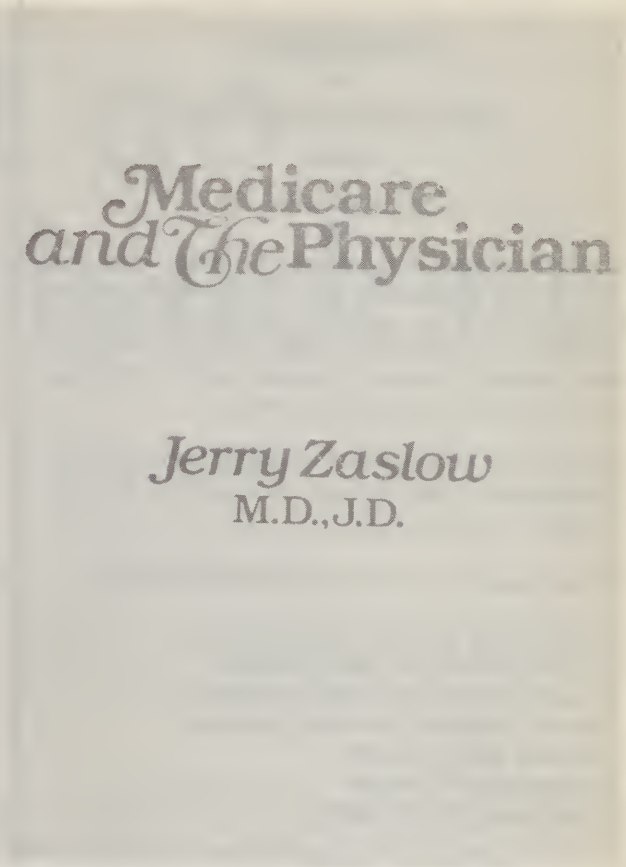


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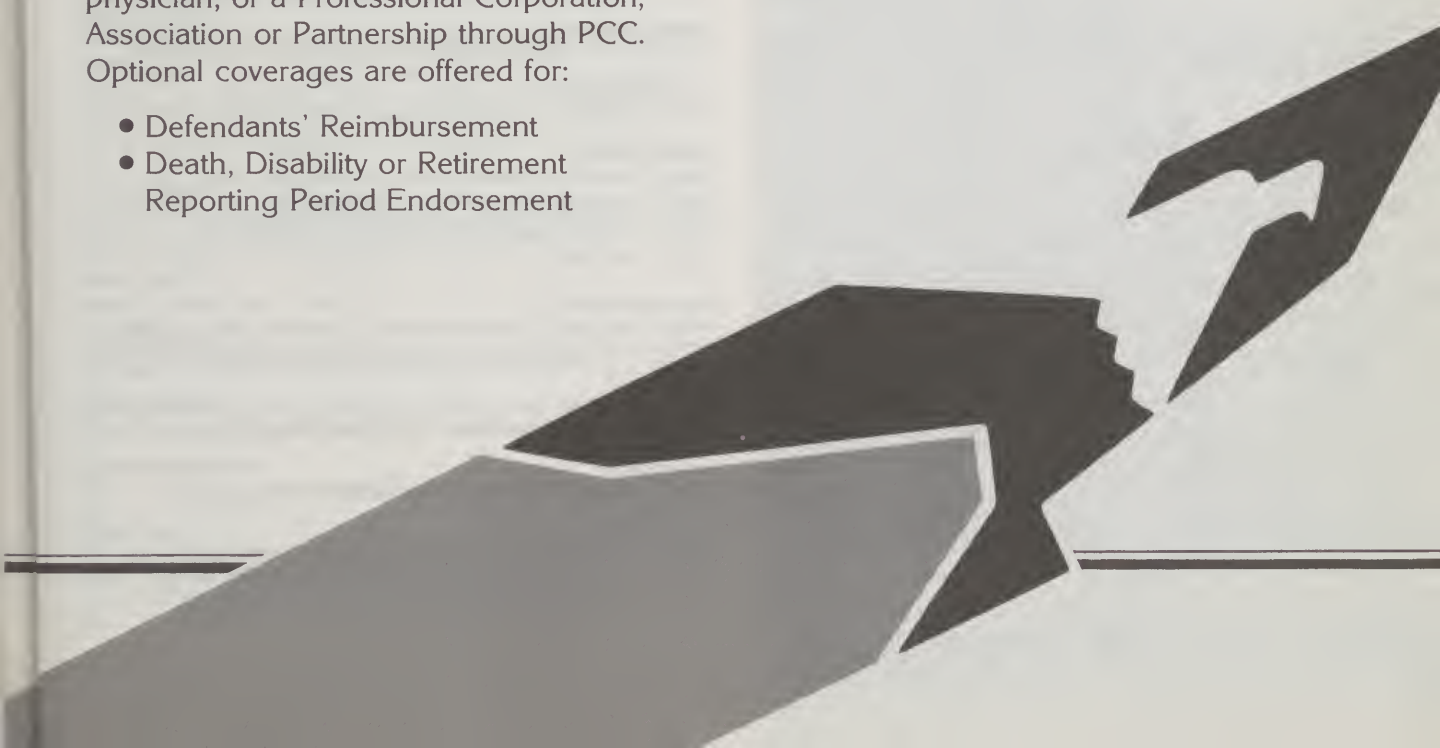

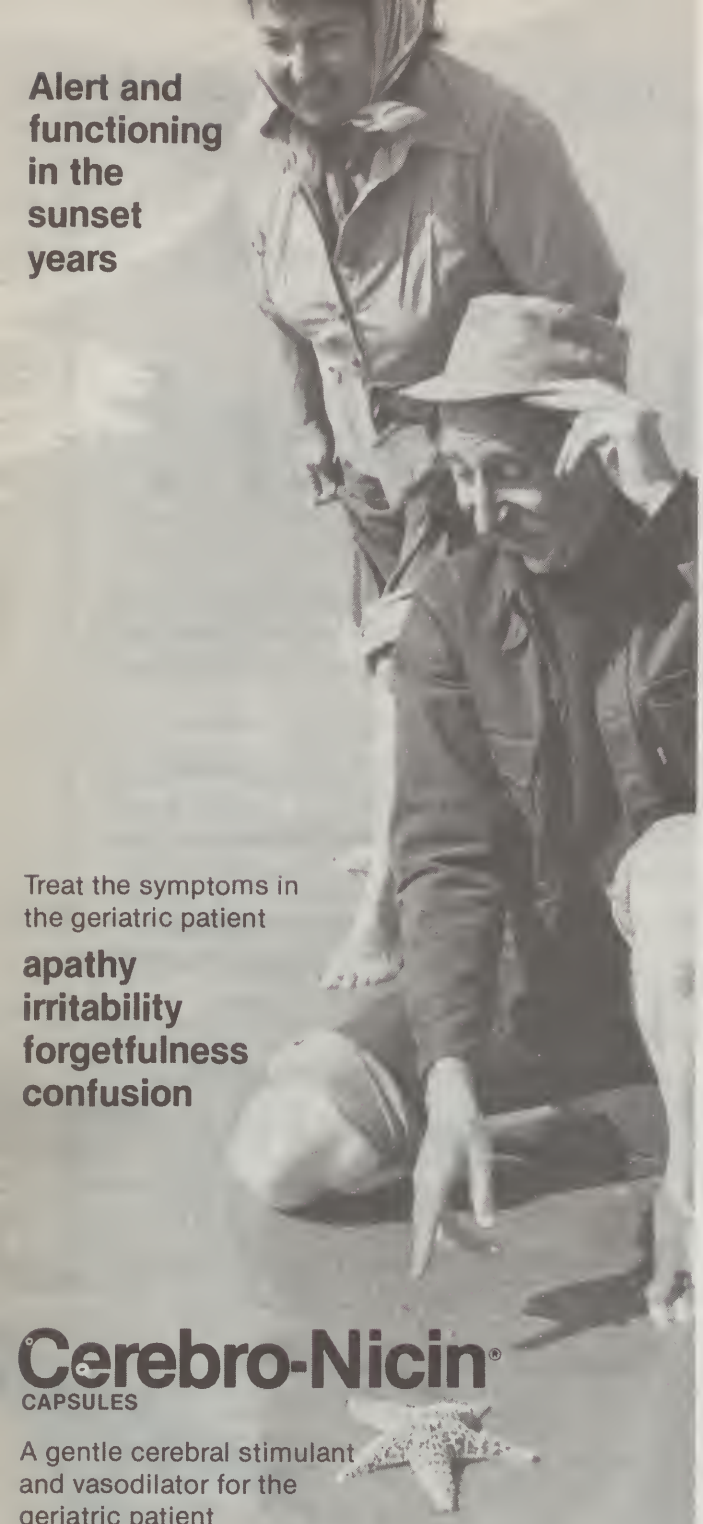

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A gentle cerebral stimulant and vasodilator for the geriatric patient

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Charles J. Carlini, MD, Obstetrics/Gynecology, 4221 Winterburn Ave., A301, Pittsburgh 15207
Bernard H. Doft, MD, Ophthalmology, 230 Lothrop St., Pittsburgh 15213
J. William Futrell, MD, Plastic Surgery, 1117 Scaife Hall, Univ. of Pgh., Pittsburgh 15261
Godfrey Gaisie, MD, Radiology, 420 N. Beatty St., Pittsburgh 15206
Stephen Gootblatt, MD, Internal Medicine, 5640 Beacon St., Pittsburgh 15217
Betty L. Grundy, MD, Anesthesiology, 1060-E Scaife Hall, Anes., Pittsburgh 15261
Linda J. Himot, MD, Psychiatry, 561 Peebles St., Pittsburgh 15221
Allen R. Hodges, MD, Pediatrics, 211 N. Whitfield St., Pittsburgh 15206
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Humberto G. Junco, MD, General Surgery, 3202 Sundale Dr., Glenshaw 15116
H. David Lipsitz, MD, Internal Medicine, 7070 Forward Ave., Pittsburgh 15217
Mark R. Mosley, MD, Internal Medicine, 1515 Locust St., 8B, Pittsburgh 15219
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Barry L. Riemer, MD, Orthopedic Surgery, 1152 Woodbine St., Pittsburgh 15210
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Karen R. Roche, MD, Plastic Surgery, 1380 Fox Chapel Rd., Pittsburgh 15238
Rajinder S. Sandhu, MD, Psychiatry, 320 2nd Ave., Tarentum 15084
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Michele S. Meltzer, MD, Internal Medicine, 709 Corinthian Ave., Philadelphia 19130
David A. Moore, MD, Emergency Medicine, 3721 Baring St., Philadelphia 19104
Elmar, O. Perez, MD, Anesthesiology, Temple Univ. Hosp., Dept. of Anes., Philadelphia 19140
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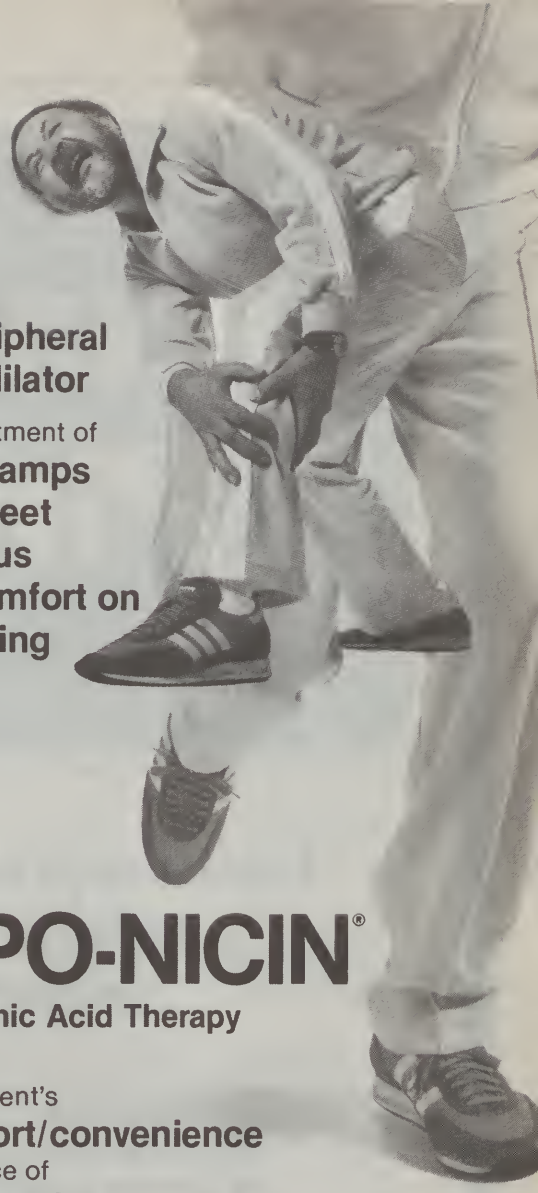

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in a special base of prolonged therapeutic effect.
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Niacinamide.....75 mg.
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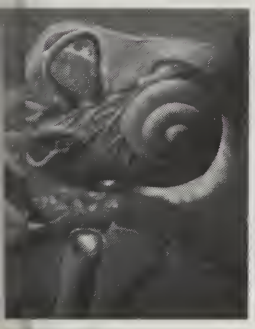

***UPPER RESPIRATORY***

acute otitis media in children

***LOWER RESPIRATORY***

acute exacerbations of chronic bronchitis in adults —documented *Pneumocystis carinii* pneumonitis

***GENITO-URINARY***

recurrent urinary tract infections

***GASTRO-INTESTINAL***

shigellosis

**Before prescribing, please consult complete product information, a summary of which follows:**

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*Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

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**For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.**

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**Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.**

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

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*ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:*

*Usual adult dosage:* 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

*PNEUMOCYSTIS CARINII PNEUMONITIS:*

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose™ packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose™ packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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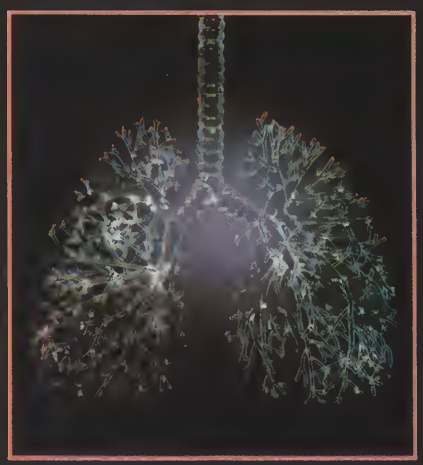

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Bactrim may be used for this indication when, in the physician's judgment, it offers an advantage over a single antimicrobial agent.

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# Pennsylvania Medicine

Vol. 83, No. 10 OCTOBER 1980

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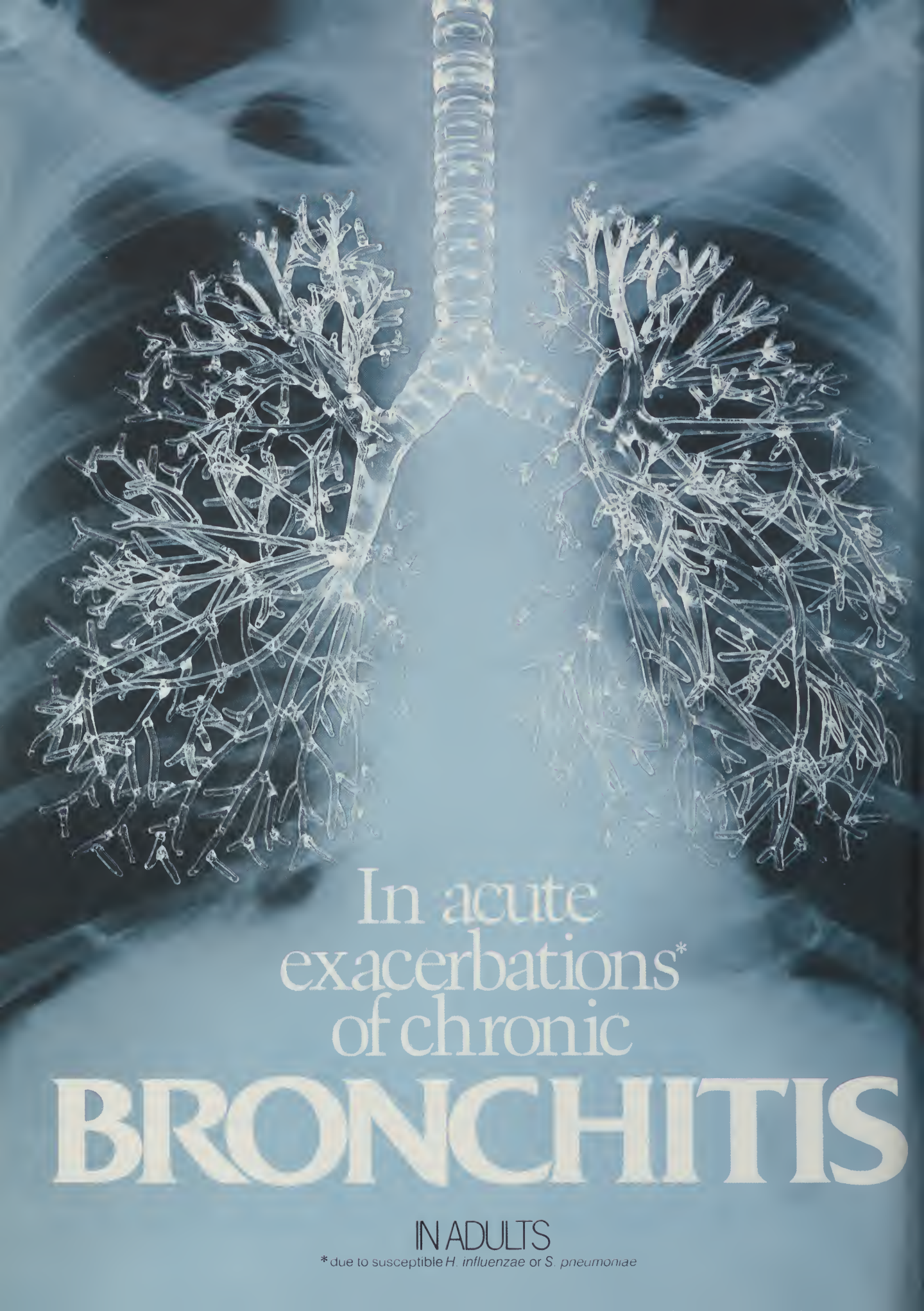
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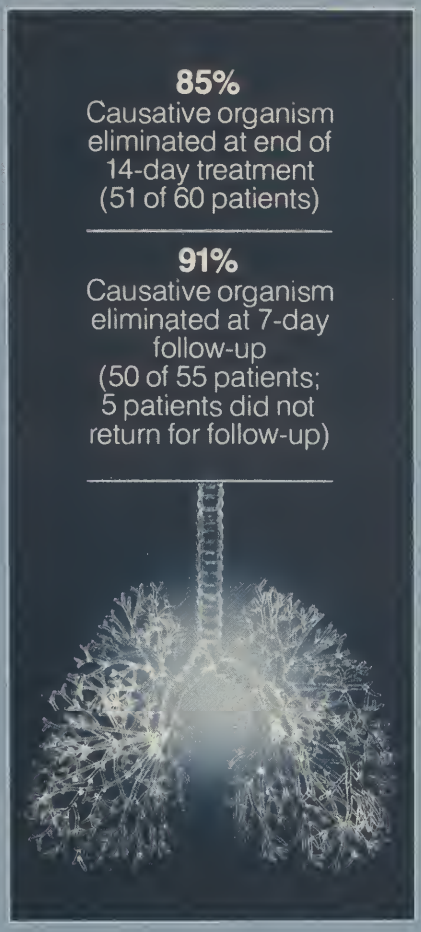


- ☐ Low incidence of diarrhea and bronchial superinfection.
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- ☐ May be used in patients allergic to penicillins and cephalosporins.
- ☐ Convenient b.i.d. dosage encourages compliance.
- ☐ During therapy, maintain adequate fluid intake. Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma.

**Bactrim is indicated in acute exacerbations of chronic bronchitis in adults when in the physician's judgment it offers an advantage over a single antimicrobial agent.**

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

# BACTRIM™ DS

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Please see next page for summary of product information.

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**BOARD OF TRUSTEES MEETS ON MEMBERSHIP SURVEY**

The PMS Board of Trustees met September 13 and 14 to study the results of the membership survey conducted by Hay Associates this spring. The Board expects to use survey findings to set Society objectives and for future planning. The November issue of PENNSYLVANIA MEDICINE will carry further details on the survey.

**EASE OF COMMUNICATION INTENT OF NEW Rx LAW**

Although it caused a minor furor at the time of its effective date, September 2, 1980, Act 86 of 1980 is intended to improve communications, not complicate them. The new law requires that the name of the prescribing physician appear on each prescription in printed form. The name can be hand printed, stamped, or preprinted commercially, according to PMS legal counsel. The Act's author, Joseph V. Zord, Jr., of Pittsburgh, said, "My intent in sponsoring Act 86 was to assure (that a) pharmacist receiving a prescription can contact the prescribing physician. . .a physician's name can be printed by hand as long as it's legible."

**LEGISLATIVE PRESCRIBING BAD MEDICINE, PMS SAYS**

The Pennsylvania Medical Society opposes amphetamine misuse, but it also opposes legislating professional methodology. This was the testimony of Harry E. Serene, MD, of Pittsburgh, a member of the PMS Council on Legislation, at a public hearing on S.B. 184 August 27. The PMS Board of Trustees on August 23, 1978 adopted a policy "that amphetamines as an anorexiant be identified as a specific example of 'inappropriate use of drugs'." But the Society also is opposed to S.B. 184, which would prohibit prescribing or dispensing amphetamines or sympathomimetic amine drugs "for the treatment of obesity, fatigue, nonclinical depression, mood states, or to induce elevated human behavior, cognitive, or physical performance." PMS opposes the concept which soon could put lawmakers in a maze in an effort to legislate uses for drugs about which they have no professional knowledge.

**SENATE APPROVES ACT 111 CHANGES**

H.B. 2204, a bill permitting the Catastrophe Loss (CAT) Fund to pay claims which do not originate before an Act 111 arbitration panel, was amended and adopted by the Senate September 23. The amendments, awaiting House approval, are Insurance Department proposals intended to maintain the CAT Fund despite increasing payouts. Under the amendments, a physician's basic limits coverage will increase to $150,000/$450,000 if the fund pays out more than $20 million in any one year, and to $200,000/$600,000 if it pays out more than $30 million in a year. Originally the department proposed an immediate increase in physicians' basic limits coverage to $200,000/$600,000, but PMS was successful in its effort to modify that. PMS also was successful in amending the law to give the physician's insuror the right to approve "any settlement entered into by the director (of the CAT Fund) on behalf of its insured health care provider." Other amendments would eliminate the $7.5 million floor, substitute a $15 million cushion, and eliminate the 10 percent ceiling on the annual surcharge.

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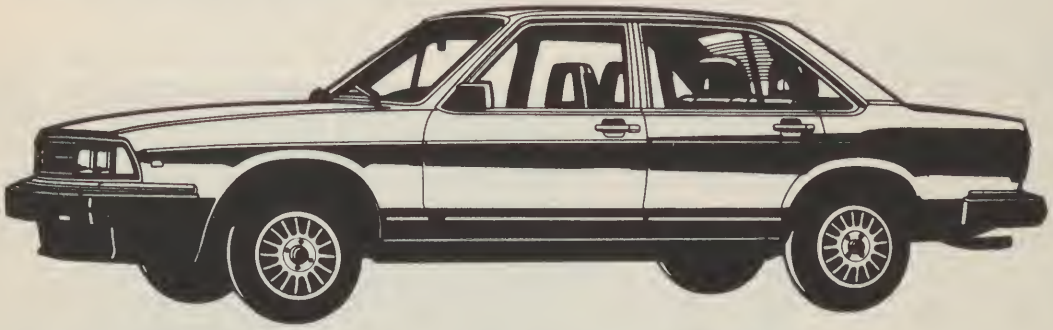

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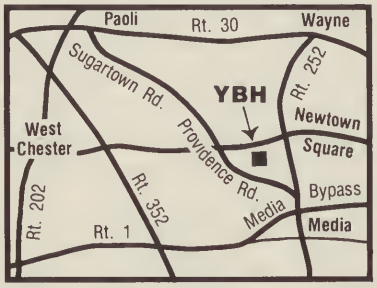


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20 Erford Road
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# editorial

## Risk management programs need physician input

The importance of medical staff participation in risk management programs can not be overemphasized. The physician very often is the only guide to preventing untoward occurrences in patient care. His diligence in drawing attention to problems is directly related to improvement of patient care.

Risk management is a rapidly growing field which encompasses many disciplines within the hospital. Although the concept arises from insurance carriers, it applies to areas other than malpractice claims. In some states, it is required by law. Administration, medical and nursing staff, and hospital employees all have roles to play in a successful risk management, quality assurance program.

Just as risk management is multidisciplinary, so is it multifaceted in definition. It may be defined as the process of identifying, evaluating, and treating risks that carry a financial threat to the hospital. It also provides for improved quality of care by identifying, evaluating, eliminating, or controlling incidents that give rise to unplanned patient injury. Such incidents are unexpected events which represent departures from normal acceptable routine and which occur in hospital settings and most often, although not necessarily, involve patients.

Risk management also may be defined as an attempt to manage the uncertainties in medical care as far as possible in the hospital so as to prevent or reduce bad outcomes. And finally, risk management simply could be called safety control.

The financial aspect of a risk management program is the obvious reduction and/or prevention of unnecessary malpractice claims. For many hospitals, this would be sufficient reason to initiate a program. Although monetary considerations are certainly valid, the quality assurance and safety goals of risk management are far more important. Providing high quality patient care is of the highest priority for hospitals. Patient injury may equate to financial loss but preventing injury is paramount.

Medical staff support of risk management is vital. Physicians are in a unique position relative to patient protection and thus, having detected an untoward event, may initiate a report of the incident for future prevention of events of that nature. Incident reports are the handle of risk management programs and are a method by which patient care is improved and similar occurrences are avoided. Statistical as well as actual tabulation of hazards and trends are necessary for a successful risk management program.

At present, the legal status of the incident report is unclear. A physician may hesitate to prepare a written report of a situation when the report may be obtained by a plaintiff through subpoena. Although it is understood that hospitals would contest the subpoena of incident reports, there is no guarantee that the courts would decide in favor of the defense. This ambiguity in the law is a major obstacle to physician willingness to enter into a risk management program with any enthusiasm. No matter what the merits of the program may be otherwise, already malpractice-sensitized physicians will not be inclined to participate if they think their chances of incurring a lawsuit are increased.

Incident reports initiated by a medical staff member which involve that physician himself or a fellow physician and which could involve malpractice pose difficult moral dilemmas. Implying oneself or one's colleagues in a lawsuit as a result of one's actions requires such a high degree of self-discipline and such a high personal moral code that widespread reporting is highly unlikely.

As stated in the outset, medical staff participation in a quality assurance program must be complete to ensure its success. Developing fair guidelines for correcting problems ultimately will result in better patient care, a better financial picture, and fewer legal entanglements.

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# newsfronts

## Reading's Leroy Gehris 131st PMS president

**KathyLee Santangelo**

House calls and solo practice, traditions of the good old days in medicine, are kept alive and well by Leroy A. Gehris, MD, 131st president of the Pennsylvania Medical Society.

Dr. Gehris, a 1935 graduate of Jefferson Medical College, is a general practitioner in Reading, Pennsylvania. He has maintained his solo practice for 41 years because, as he said, "It's the best way for me. Being one on one with my patients, I can guarantee that I am treating them as they should be treated."

This is just one example of how he practices the Golden Rule, "Do unto others as you would have them do unto you."

Dr. Gehris will be installed as PMS president at the Annual State Dinner, November 1, 1980. "My first priority as president," he said, "will be to assure quality health care for every citizen of the Commonwealth." In this, as in every other of his ambitions, he will be guided by the golden rule.

**Society planning**

Dr. Gehris will plan his other goals after he reviews the responses from the all-member survey conducted this year by Hay Associates of Philadelphia. As chairman of the Planning and Evaluation Committee appointed by the PMS Board of Trustees, Dr. Gehris will be designing a plan of action to keep PMS a foresighted association. He said, "I think organized medicine is on the right track. And, once we look over the survey results, we'll be able to determine the membership's priorities."

Dr. Gehris is experienced in putting his ideals into action. In 1939 he became a member of the Berks County Medical Society. This was the beginning of an active, long-standing commitment to organized medicine.

At the county level he served on the executive council for 19 years. In 1958 he served as president of the Berks County Medical Society. For 15 consecutive years, from 1954 to 1969, he was a delegate to the PMS House of Delegates.

In 1969 Dr. Gehris was elected to the PMS Board of Trustees as Trustee and Councilor of the Second District. "I was determined to have the county officers know their trustee," he said. "I didn't keep a log of all the hours I spent attending these meetings. After all, they gave me the chance to be with people like myself, people who are proud to be doctors above everything else."

**Broadening horizons**

Board obligations made frequent visits to PMS headquarters a routine part of Dr. Gehris' travels. He was a member of the Benjamin Rush Committee, the Quackery Committee, and is past chairman of the Finance Committee. He now serves on the Executive Committee and is the Board representative to the Interspecialty Committee.

On one of Dr. Gehris' first visits to the capital city, he represented Saint Joseph Hospital in Reading. He was on the executive committee of the hospital medical staff and he knew that every month the hospital was loosing thousands of dollars by treating poverty level patients. Being a man of action, he documented the legitimacy of the claims and made his way up

Capitol Hill. His climb was worthwhile because he returned to Reading with $60,000 for the hospital. This trip became the first of many trips to Harrisburg for Dr. Gehris.

In more than 20 years on the staff of Saint Joseph Hospital, he has been an associate on the orthopedic and fracture service staff. In 1956 he was president of the medical staff, and in 1974 he organized and chaired the hospital's Utilization Committee.

Between trips to county society meetings, state board meetings, and short runs to the hospital, Dr. Gehris still makes time for house calls.

**High technology plus**

He believes that if the development of high technology is one trend in medical care and medical education, there is another equally important trend, one toward more human contact. "Our medical schools cannot graduate technicians," he said. "They must strive to graduate physicians who are skilled in both the art and the science of medicine. The public wants physicians who will balance high technology with high personal touch."

For Dr. Gehris, the balance is not difficult to achieve. It is simply a corollary to the golden rule, which he practices as second nature. As natural as it is for him, it nonetheless won him recognition from the Church of Jesus Christ of Latter Day Saints. In 1967 the Church honored him with the Brotherhood Award for his outstanding service to the Reading community.

Storytelling, painting, and music are some of Dr. Gehris' favorite leisure activities. He especially enjoys his hours at the hospital because he has so many captive audiences. "I can start on one floor in the morning telling a patient about the time I packed emergency supplies on trucks headed for Stroudsburg during Hurricane Agnes," he said. "On the next floor I can share my adventures in the Army when I was stationed at Bushnell Hospital in Utah doing research on penicillin. By the time I get to the top floor, I may even be ready to tell the nurses about my horse swapping days."

PMS has one sample of Dr. Gehris' artistic talent, an oil painting which hangs in the second floor corridor of PMS headquarters. Oil painting is second among his hobbies to music, which Dr. Gehris enjoys most when his daughter, Marcia Jeanne, sings. Already she has made two recordings of religious songs, but, he said, "she is not the only star in my life. I have three others, my wife, Becky, a past president of the Pennsylvania Medical Society Auxiliary, my daughter, Linda Lee Elmer, and my granddaughter, Carolyn Elmer."


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# Presiding officers urge member input at annual meeting

A complete revision of the constitution and bylaws will be considered at the 1980 Annual Meeting of the Pennsylvania Medical Society's House of Delegates, Friday through Sunday, October 31-November 2, in the International Ballroom of the Fairmont Hotel in Philadelphia.

All reports, recommendations, and resolutions for consideration by the House will be referred to reference committees, which will hold open meetings beginning at 1:30 p.m. on Friday, October 31. The opening session of the house on Friday morning will hear the report of President Matthew Marshall, Jr., MD, and the presidential address of President Elect Leroy A. Gehris, MD.

Reference committee hearings are open to all PMS members and guests, as well as to interested outsiders and the press. All members have the right to speak on reports and resolutions at reference committee hearings, and are encouraged to participate by D. Ernest Witt, MD, speaker of the House, and Donald E. Harrop, MD, vice speaker. Nonmember guests also may be recognized and permitted to speak at the discretion of reference committee chairmen.

Reference committees of the PMS House of Delegates establish their own rules on time limits for comments, repetitious statements, and number of opportunities to speak. The aim of the committees, however, is to give each person an opportunity to testify fully on the questions. To this end, those who testify once are asked to wait until all others have been heard before requesting to speak again, except in those cases where clarification is requested.

Following the open hearings, reference committees meet in executive session to write their reports. These reports become the official business of the House of Delegates, and in 1980 will be considered by the full house on November 1 and 2.

Nominations and elections begin on Friday afternoon, and, for contested offices, will be completed Saturday morning. The 1980 house will elect a vice president (who becomes president automatically in two years), a secretary, a speaker, a vice speaker, six delegates and six alternate delegates to the AMA House of Delegates, two members of the Board of Trustees, and a district censor from each component society.

Reference Committee A will hold hearings on the revision of the Constitution and Bylaws along with additional amendments to that document. Among the proposed amendments are the following: unified membership, which would require AMA membership as a condition for PMS and component society membership; a change in the size of a quorum in the House of Delegates from 40 members to 75; and changing the speaker and vice speaker of the House of Delegates from nonvoting to voting members of the Society's Board.

The Committee on Constitution and Bylaws also will recommend action to correct the current imbalance in the number of trustees elected each year, so that four trustees will be elected to a three year term each year. The current three year pattern is five, five and two.

Generally items for House of Delegates consideration are referred as follows: Reference Committee A—amendments to the Constitution and Bylaws; Reference Committee B—all recommendations dealing with educational and scientific matters; Reference Committee C—all hospital, health planning, and health care delivery issues; Reference Committee D—legislative issues; Reference Committee E—third party payor issues, including government programs and all professional liability insurance matters; Reference Committee F—all member service and membership promotion affairs; Reference Committee G—reports of officers, financial matters, officers' activities.


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# Health spending continues upward spiral

The nation spent in 1979 an estimated $212.2 billion, an amount equal to 9 percent of the gross national product on health care, according to Health and Human Services Secretary Patricia Harris.

On a per capita basis, 1979 health spending from all sources amounted to an estimated $943 per person. Of that amount, $406 or 43 percent represented public spending.

These latest comprehensive health spending estimates were compiled by HHS' Health Care Financing Administration. They are published in the current issue of HCFA's quarterly journal, *Health Care Financing Review.*

Outlays for health care benefits by the medicare and medicaid programs amounted to $29.3 billion and $21.7 billion respectively, combining to pay for 27 percent of all personal health care in the nation. Benefits for hospital care alone amounted to $29.7 billion for both programs.

Other highlights in the report include:

- Health spending in 1979 increased 12.5 percent from 1978 levels, up from 11 percent growth in 1978.
- Expenditures for health care included $54.4 billion in premiums to private health insurance, $60.9 billion in federal payments, and $30.5 billion in state and local government funds.

The $85.3 billion bill for hospital care represented 40 percent of total health care spending in 1979. These expenditures increased 12.5 percent over 1978.

Spending for physician services increased 13.4 percent to $40.6 billion, 19 percent of all health care spending.

All third parties combined, including private health insurers, governments, philanthropy, and industry, financed 68 percent of the $188.6 billion in personal health care in 1979. This financing ranged from 92 percent of hospital care services to 64 percent of physicians' services and 39 percent of the remainder.

Direct payments by consumers in 1979 reached $60 billion, 32 percent of all personal health care expenses.

To obtain a copy of the publication, send a request for *Health Care Financing Review,* fall issue, to ORDS Publications, Room 1E9 Oak Meadows Building, 6340 Security Blvd., Baltimore, MD 21235.

## Tuition costs soar for medical school

Medical students will be paying from $5,500 to more than $10,000 in tuition alone at Pennsylvania schools in 1980-81.

First year tuition costs start as low as $5,550 at the Pennsylvania State University College of Medicine, Hershey. For first year students at Hahnemann Medical College, tuition costs are $10,185.

Tuition to the state's osteopathic school, Philadelphia College of Osteopathic Medicine, is in the middle of the range at $7,672. It is higher than Temple University and the University of Pittsburgh, but lower than Jefferson Medical College, Medical College of Pennsylvania, and the University of Pennsylvania.

## UR physicians meet

The American College of Utilization Review Physicians will offer a national seminar October 25-26, 1980 at The Copley Plaza, Boston, Mass.

Participants will earn Category 1 credit hours. For further information, write Betty J. Hamman, Executive Director, American College of Utilization Review Physicians, 1108 North Second Street, Harrisburg, PA 17102.


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# PMS workers' compensation plan rebates 47%

A 47 percent refund totaling $160,023 has been returned to PMS members participating in the Society's workers' compensation insurance plan.

Additional premium discounts for the period ending April 1, 1980 amounted to $8,676 making the overall reduction in gross cost 48.3 percent or $168,699.

According to Casualty Reciprocal Exchange, a member of the Dodson Insurance Group, Kansas City, MO, premium volume was up 54 percent over that of last year. Casualty Reciprocal Exchange also reported that most of the savings class was free from losses last year.

More information on this membership benefit may be obtained from L. Riegel Haas at PMS headquarters, 20 Erford Rd., Lemoyne, PA 17043.

## Blue Shield releases 1980 procedure manual

Pennsylvania Blue Shield recently made available to physicians its 1980 edition of the *Procedure and Terminology Manual.*

Many important changes to the prior editions are included in the manual. Each change is annotated with a single asterisk in the left hand margin of the page.

Questions regarding any portion of the manual should be directed to a Blue Shield representative or one of the following offices: Eastern Pennsylvania Blue Shield, 1333 Chestnut St., Philadelphia, PA 19107, telephone (215) 564-2131 or Western Pennsylvania Blue Shield, One Smithfield St., Pittsburgh, PA 15222, telephone (412) 471-7916.

## Some on medicaid combine drugs, abuse program

Investigations by the state public welfare department have disclosed the need to alert physicians to the potential for abuse of prescription drugs by medical assistance recipients.

The executive deputy auditor general reported that the department's investigations revealed that medicaid recipients are combining drugs to obtain desired effects. Recipients are substituting combinations such as Talwin and Pyribenzamine for hard drugs like heroin that are becoming more difficult to obtain.

The investigations note that recipients are using the program to increase their income by selling prescription drugs, or to abuse prescription drugs.

The department plans to monitor, by its automated claims processing system, the use of drug combinations that indicate possible abuse. The department will terminate the provider agreement of any provider who abuses the program. Recipients who abuse the program will be restricted to a single pharmacy or a specific practitioner.

## Health department revises gonorrhea treatment

For the fifth year in a row, gonorrhea in 1979 was the most frequently reported disease, the Pennsylvania Department of Health has announced. Of the 28,307 cases reported in 1979, 15,779 were in Philadelphia. Just under a million cases of gonorrhea were reported nationally in 1979, with the Center for Disease Control reporting 998,795 cases of gonorrhea, and 25,012 cases of infectious syphilis.

The Pennsylvania Department of Health has revised the treatment schedule for sexually transmitted diseases and has available its recently published booklet, "Sexually Transmissible Disease Recommended Diagnostic Strategy and Treatment Schedule." The Booklet was prepared by the Division of Acute Infectious Disease Control of the health department. Robert D. Gens, MD, is division director. David Schlossberg, MD, of Polyclinic Medical Center, Harrisburg, served as consultant.

It is available from the Division of Acute Infectious Disease Control, Pennsylvania Department of Health, P.O. Box 90, Harrisburg, PA 17120.

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Pennsylvania Department of Health advisory

# Influenza vaccine recommendations for 1980-81 issued

**John L. Randall, MD**

Influenza virus infections occur every year in the United States, but they vary greatly in incidence and geographic distribution. Infections may be asymptomatic, or they may produce a spectrum of manifestations, ranging from mild upper respiratory infection to pneumonia and death.

Influenza viruses A and B are responsible for only a portion of all respiratory disease, but are uniquely able to cause periodic widespread outbreaks of febrile respiratory disease in adults and children. Influenza epidemics frequently are associated with deaths in excess of the number normally expected. During the period from 1968 to 1980, epidemics of influenza in the United States caused an estimated number of deaths in excess of 150,000.

Efforts to prevent or control influenza in the United States have been aimed at protecting those at greatest risk of serious illness or death. Observations during influenza epidemics have indicated that influenza-related deaths occur primarily among chronically ill adults and children and in older persons, especially those over age 65. Therefore, annual vaccination is recommended for these "high-risk" individuals.

Influenza A viruses can be classified into subtypes on the basis of 2 antigens: hemagglutinin (H) and neuraminidase (N). Four subtypes of hemagglutinin (H0-H3) and 2 subtypes of neuraminidase (N1, N2) are recognized among viruses causing widespread disease among humans. Immunity to these antigens reduces the likelihood of infection and reduces the severity of diseases in infected persons. However, there may be sufficient antigenic variation (antigenic drift) within the same subtype over time that infection or immunization with one strain may not induce immunity to distantly related strains.

Although influenza B viruses have shown much more antigenic stability than influenza A viruses, antigenic variation does occur and was noted in the 1979-80 influenza season. As a consequence, the antigenic composition of the most current strains is considered in selecting the virus strain(s) to be included in the vaccine.

The predominant strain of influenza virus in the United States during 1979-80 was B/Singapore/79, a variant of the prototype B/Hong Kong/72. Most reported influenza B outbreaks involved children and young adults, but outbreaks also occurred in older populations. Excess mortality due to pneumonia and influenza was noted in association with influenza B activity in 1979-80, confirming that infections with this virus can cause serious illness and death.

Isolates of influenza A virus of the H3N2 subtype, similar to A/Texas/77 and A/Bangkok/79, were obtained from sporadic cases of febrile respiratory disease. A/Bangkok/79 strains show significant antigenic drift from A/Texas/77. Influenza A/Brazil/78 (H1N1)-like viruses caused outbreaks of illness among young people.

## Influenza virus vaccine

Influenza vaccine for 1980-81 (official name: Influenza Virus Vaccine, Trivalent) will consist of inactivated trivalent preparations of antigens representative of influenza viruses expected to be prevalent: A/Brazil/78 (H1N1), A/Bangkok/79 (H3N2), and B/Singapore/79. The formulation will contain 7 micrograms of hemagglutinin of each antigen in each 0.5 ml dose.

Persons 28 years and older will require only 1 dose. Because of lack of previous contact with H1N1 strains, persons less than 28 years of age who did not receive at least 1 dose of the 1978-79 or 1979-80 trivalent vaccine will require 2 doses of the 1980-81 vaccine. Those who received the 1978-79 or 1979-80 vaccine will require only 1 dose. The vaccine will be available as whole virion (whole-virus) and subvirion (split-virus) preparations. Based on past data, split-virus vaccines have been associated with somewhat fewer side effects than whole-virus vaccines in children. Thus, only split-virus vaccines are recommended for persons less than 13 years of age.

## Recommendations

Annual vaccination is recommended strongly for all individuals at increased risk of adverse consequences from infections of the lower respiratory tract. Conditions predisposing to such risk include (1) acquired or congenital heart disease associated with altered circulatory dynamics, actual or potential (for example, mitral stenosis, congestive heart failure, or pulmonary vascular overload); (2) any chronic disorder with compromised pulmonary function, such as chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, severe asthma, cystic fibrosis, neuromuscular and orthopedic disorders with impaired ventilation, and residual pulmonary dysplasia following the neonatal respiratory distress syndrome; (3) chronic renal disease with azotemia or the nephrotic syndrome;

*Dr. Randall is a consultant on infectious diseases to the Pennsylvania Department of Health. He is on the staff of the department of family and community health at Lancaster General Hospital.*

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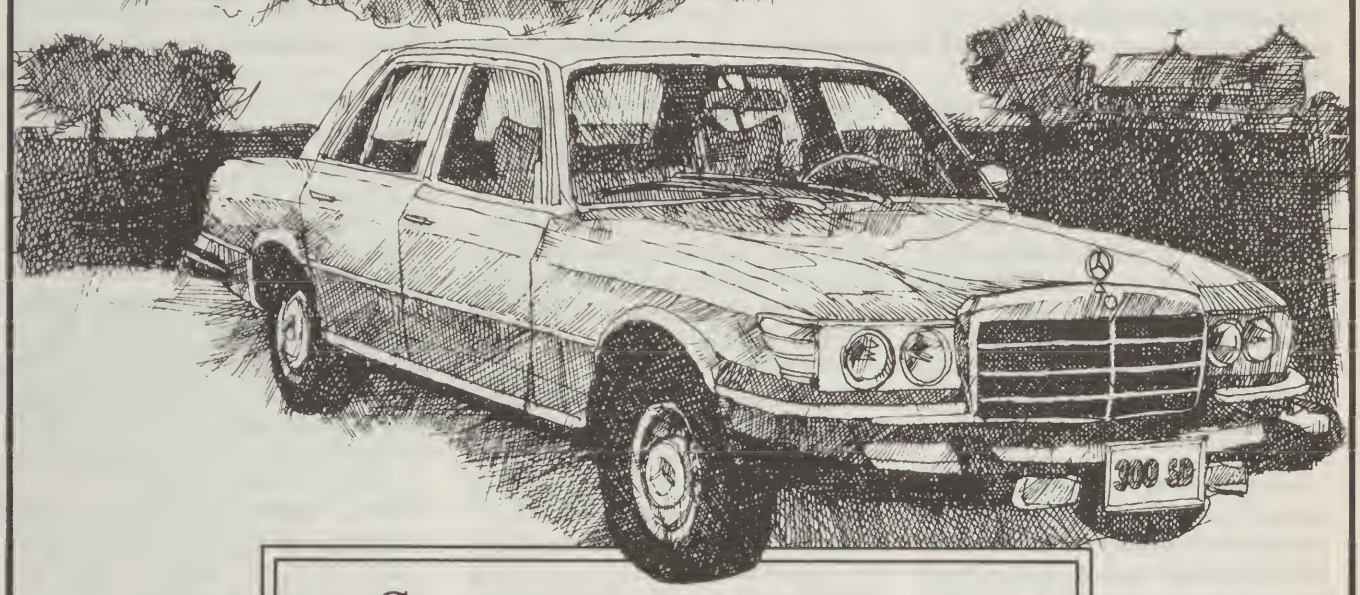


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TABLE I
Influenza Vaccine* Dosage, by age, 1980-81

| Age group | Product | Dosage (ml) | Number of doses |
|---|---|---|---|
| 28 years and older | whole virion (whole virus) or subvirion (split virus) | 0.5 | 1 |
| 13 - 27 years | whole virion (whole virus) or subvirion (split virus) | 0.5 | 2+ |
| 3 - 12 years | subvirion (split virus) | 0.5 | 2+ |
| 6 - 35 months ++ | subvirion (split virus) | 0.25 | 2+ |

Contains 7 $\mu$g each of A/Brazil/78 hemagglutinin antigens in each 0.5 ml.
+ 4 weeks or more between doses; both doses essential for good protection, unless the individual received at least 1 dose of 1978-79 or 1979-80 vaccine. In latter instance, 1 dose is sufficient.
++ Based on limited data. The likelihood of febrile convulsions is greater in this age group, therefore special care should be taken in weighing relative risks and benefits.

(4) diabetes mellitus and other metabolic diseases with increased susceptibility to infection; (5) chronic, severe anemia, such as sickle cell disease; and (6) conditions which compromise the immune mechanism, including certain malignancies and immunosuppressive therapy.

Vaccination also is recommended for older persons, particularly those over age 65, because excess mortality in influenza outbreaks occurs in this age group.

In considering vaccination of persons who provide essential community services or who may be at increased risk of exposure, such as medical care personnel, the inherent benefits, risks, and cost of vaccination should be taken into account.

Table 1 summarizes vaccine and dosage recommendations by age group for 1980-81.

**Use in pregnancy**

Only in the pandemics of 1918-19 and 1957-58 has strong evidence appeared relating influenza infections to increased maternal mortality. Although several studies have reported an increased risk of congenital malformations and childhood leukemia among children born to women who had influenza infection during pregnancy, other studies have not shown an increased risk. The issue remains unsettled.

Physicians prudently limit prescription of drugs and biologics for pregnant women. No evidence, however, has been presented to suggest that influenza vaccination of pregnant women poses any special maternal or fetal risk. Furthermore, because influenza vaccine is an inactivated viral preparation, it does not share the theoretical risks that impel caution in the use of live-virus vaccines. Taking the above uncertainties into account, physicians should evaluate pregnant women for influenza immunization according to the same criteria applied to other persons.

**Side effects and adverse reactions**

Recent influenza virus vaccines have been associated with few side effects. Local reactions, consisting of redness and induration at the site of injection lasting one to two days, have been observed in less than one-third of vaccinees. Three types of systemic reactions to influenza vaccines have been described:

1. Fever, malaise, myalgia, and other systemic symptoms of toxicity, although infrequent, occur more often in children and others who have had no experience with influenza viruses containing the vaccine antigen(s). These reactions, which begin 6-12 hours after vaccination and persist 1-2 days, are usually attributed to the influenza virus itself (even though it is inactivated) and constitute most of the side effects of influenza vaccination.

2. Immediate responses, presumably allergic, such as flare and wheal or various respiratory expressions of hypersensitivity, occur extremely rarely after influenza vaccination. They probably derive from sensitivity to some vaccine component, most likely residual egg protein. Although current influenza vaccines contain only a small quantity of egg protein, on rare occasions they can provoke hypersensitivity reactions. Individuals with anaphylactic hypersensitivity to eggs should not be given influenza vaccine. This would include persons who, upon ingestion of eggs, develop swelling of the lips or tongue or experience acute respiratory distress or collapse.

3. Guillain-Barré syndrome (GBS) is an uncommon illness characterized by ascending paralysis that is usually self-limited and reversible. Though most persons with GBS recover without residual weakness, approximately 5 percent of cases are fatal.

Before 1976, no association of GBS with influenza vaccination was recognized. That year, however, GBS appeared in excess frequency among persons who had received the A/New Jersey/76 swine influenza vaccine. For the 10 weeks following vaccination, the excess risk was found to be approximately 10 cases of GBS for every million persons vaccinated, an incidence 5-6 times higher than that in unvaccinated persons. Younger persons (under 25 years) had a lower relative risk than others and also had a lower case-fatality rate.

Analysis of data from GBS surveillance during the 1978-79 influenza season and provisional data from the 1979-80 influenza season suggest that in contrast to the 1976 situation, the risk of GBS in vaccinees was not significantly higher than that in nonvaccinees. Nonetheless, persons who receive influenza vaccine should be made aware of this possible risk as compared with the risk of influenza and its complications.

REFERENCES

1. *Infectious Diseases*, Vol. 10, No. 8, pp:24-26, August, 1980.

## Fraud and abuse control act

# New weapon targets medicaid mills, hits physicians

**Fred Speaker, Esq.**

By the time this article is published, all Pennsylvania physicians will have received a one-page Provider Agreement from the Department of Public Welfare. All physicians who choose to participate in the Medical Assistance Program, medicaid, must sign the agreement.

Those physicians who sign agree "to know and to comply with all applicable" statutes, thus mandating knowledge of the provisions of the "Fraud and Abuse Control" provision of the Public Welfare Code.[1] This new article,[2] effective on August 11, 1980, was enacted to create a new weapon against "medicaid mills." It contains, however, provisions which are potential pitfalls for honest, law-abiding physicians as well.

One feature of the new law that controls all physicians who sign a provider agreement[3] is the requirement that they "maintain for a minimum of four years appropriate *medical and financial records* to fully support . . . [their] claims and charges."[4] In addition, "[s]uch records shall at reasonable times be made available for inspection, review and copying by the department [of Public Welfare] or by other authorized State officers."[5]

Perhaps as an answer to any claim that such potential disclosure of patients' records could be a breach of confidentiality or an invasion of the patients' rights of privacy, the new legislation provides that:

> Any person applying for medical assistance benefits shall authorize the department to inspect, review and copy any and all medical records relating to services received by the applicant or by any person for which the applicant is legally responsible.[6]

Another provision of the new law which will have general application is a requirement that the participating physician "not refuse to render services to any recipient on the basis of sex, race, creed, color, national origin, or handicap."[7] Of course, the physician "is free to accept or reject . . . [any] recipient as a patient,"[8] but the physician can not do so for any of the mentioned reasons.

All payments under the program constitute full reimbursement and must not exceed the usual and customary charges made to the general public. Furthermore, physicians may not charge additional payments for covered services "unless authorized by law or regulation; nor . . . for other services to supplement a covered service."[9] Nor may physicians "factor, assign, reassign, or execute a power of attorney for the rights to any claims or payments for services rendered"[10] under the program except for the use of accounts receivables as collateral at a lending institution.[11]

The new act sets forth a series of offenses including fraud, kickbacks, duplicate claims, claims for services not rendered, charging too much, treating without the patient's consent (unless in an emergency), conspiracy, and treating without checking the patient's medical assistance card.[12] Most of the offenses are felonies, punishable by up to seven years imprisonment and a $15,000 fine.[13] In addition to the criminal penalties, an offending physician may be disqualified from further participation in the medicaid program and may be subject to a civil suit to recover twice the amount of excess payments made.[14]

The new act also details provisions which affect any physician who owns or works in a "shared health facility" which is defined as:

> an entity which provides the services of three or more health care practitioners, two or more of whom are practicing within different professions, in one physical location. To meet this definition, the practitioners must share any of the following: common waiting areas, examining rooms, treatment rooms, equipment, supporting staff or common records. In addition, to meet this definition, at least one practitioner must receive payment on a fee-for-services basis, and payments under the medical assistance program to any person or entity providing services or merchandise at the location must exceed thirty thousand dollars ($30,000) per year.[15]

Because of the complexity of the provisions governing a shared health facility, anyone who is interested should obtain a copy of the new law by requesting it from PENNSYLVANIA MEDICINE.

The new law is far-reaching and potentially powerful. It may discourage some physicians from continuing to participate in the medicaid program and may encourage others to stop treating medicaid patients. It surely should convince physicians who continue to participate to be most careful about monitoring their participation.

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*

1./ 62 P.S. §§101 to 1503.
2./ Act of June 10, 1980 (P.L. , No. 105); 62 P.S. §§1401 to 1411.
3./ 62 P.S. §1401.
4./ 62 P.S. §1402(b) (emphasis added).
5./ *Ibid.*
6./ 62 P.S. §1404(c).
7./ 62 P.S. §1405(b).
8./ 62 P.S. §1405(a).
9./ 62 P.S. §1406.
10./ 62 P.S. §1402(c).
11./ *Ibid.*
12./ 62 P.S. §1407(a).
13./ 62 P.S. §1407(b).
14./ 62 P.S. §7 1407(c) (1).
15./ 62 P.S. §1401.

## MCP annual symposium studies sleep disorders

The Medical College of Pennsylvania's psychiatry department will sponsor its fourteenth annual symposium on Sunday, November 9, 1980.

This year's topic is "Psychodynamic implications of the physiological studies on sleep disorders." Moderating the program will be Leo Madow, MD, professor and chairman of the psychiatry department at MCP.

Speakers will include Drs. Christian Guilleminault, David Kupfer, Peter Hauri, Constantin Soldatos, and Gerald Vogel.

For further information contact Mrs. Maureen Kurzinsky, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129; (215) 842-6923.

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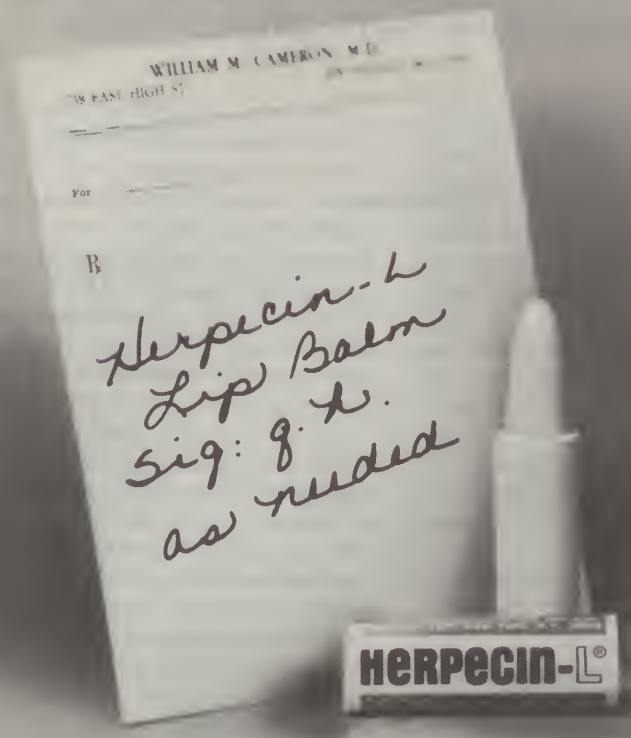


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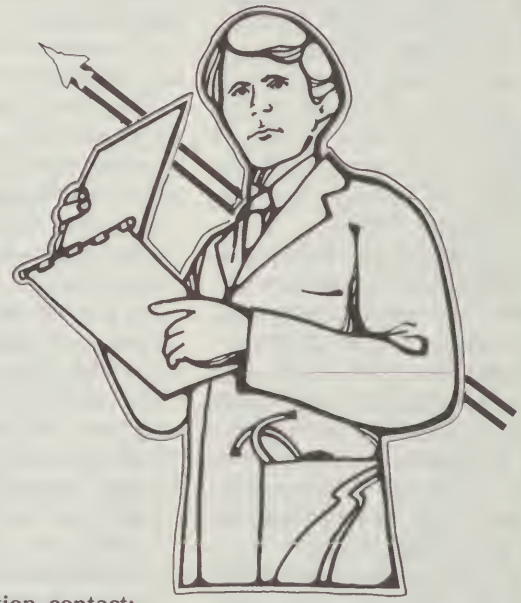

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# Government sees competition controlling medical costs

John W. Burnside, MD

"It's called Washington, District of Confusion, by insiders who immediately dubbed the new Department of Health and Human Services 'H2S'. It is the center of tremendous talent, but there is great confusion for neophytes." John Burnside thus describes Washington and its people as he saw them during the year he was there as a Robert Wood Johnson Health Policy Fellow. He spent the year on the staffs of U.S. Senator H. John Heinz, III, of Pennsylvania and U.S. Representative Richard Gephardt of Missouri. In spite of the initial confusion, Dr. Burnside says, "I left Washington with an upbeat feeling about our federal government—it does work and we can work with it. I'm optimistic." In this article he shares some insights with us. Dr. Burnside returned from Washington last month to new duties as chairman of the department of medicine at the Pennsylvania State University College of Medicine.

An interesting, subtle, and real shift in thinking can be detected in Washington. You can hear a new diction with words like market forces, deregulation, open competition, and consumer choice. In health subcommittee hearings, new procompetition gurus like Havinghurst and Enthoven are frequent participants. Perhaps there is even the inkling seeping under the cracks that government cannot do it all for all. A look at the federal budget, of course, belies any substantive change but perhaps the budget itself is one reason for serious reconsideration of the way to Camelot.

**Focus on health care**

Of all the federal targets, why should health care be the focus of attention? The first and most noted reason is cost, both total cost and the federal share of that cost. Current per capita expenditures for health care are in excess of $863 for every man, woman, and child. Of the total $192.4 billion in 1978, the government share was 40.6 percent and rising. (In 1966 the government share was 25 percent.) This staggering amount accounts for 9.1 percent of all goods and services in the United States.

The rise in health costs has pushed us into a service oriented economy. For the first time in history, more than half of our gross national product is in services rather than goods. No one is certain what this portends but it makes economists nervous.

Money is the oil of the Washington juggernaut and those who seek to exercise power recognize that fiscal manipulation is the key. Previous legislators, however, locked much of their power in law. Of the entire federal budget only a small percentage can be manipulated—perhaps 18 percent; the rest is law. Most of that law contains entitlements; those legislators who try to remove entitlements become transients in the city.

A second reason for concern about the health care of our nation is the large, uncovered population. An estimated 25 million people or 12 percent of our citizens have no health insurance either public or private. To these folk, catastrophic illness has real meaning.

A third item relates to the distribution of health services. This is far more difficult to quantitate. There exists an uneasiness that some are unserved while others are overserved.

Quality takes a distant fourth place as a reason for scrutiny. The surgeon general's unheralded report, *Healthy People,* should have been cause for celebration. It was largely superseded in the press by the resignation of Secretary Califano. It did, however, display statistics reassuring to those concerned about the health of Americans. Better health care is no longer the clarion call of proponents of an increased federal role.

**Historical background**

For years, Congress has considered a variety of ways of changing the federal role in personal health care services. The essence of most of these early attempts at national health insurance legislation was to give the government more responsibility for

the financing, the regulation, and in some, the organization of delivery systems. This procession from Truman's Proposal for National Health Insurance through Johnson's New Society saw its greatest actual legislation in 1965 when medicare became law.

This golden age of social legislation had two special facilitators, a healthy economy and a trusting relationship between Congress and the executive branch. Neither now exists. Previous strangers, inflation and recession have coupled and there is no love lost between Congress and the executive branch.

Earlier legislation was conceptual. Details were left to the enabling regulations of the responsible executive department. This relationship came unglued in the Nixon years. As a result, legislation has become ponderously detailed and designed to lock a department to a precisely prescribed mode of action.

### Less government

The pendulum of more government programs stopped in 1979. Two significant events marked this year in reference to health legislation. An astounding revision of the Kennedy National Health Insurance Bill was offered. It called for participation by the private sector to an extent unthinkable in the original draft.

The second was the defeat of the administration's Hospital Cost Containment Bill. To be sure, this was beaten as much on its internal inconsistency as its philosophy, but there was open floor discussion calling to question the conventional wisdom of increased government regulation.

In 1980 it seems that the pendulum has indeed reversed. The Senate actually took a whack at entitlements with the disability amendments. No reduction to the currently disabled was called for but future beneficiaries will receive less. Regulations and regulatory agencies received more congressional scorn than in the last two decades combined.

The hospital industry, the most effective health lobby in Washington, presented its antiregulation case well and continues to do so. It is convinced many regulations do not accomplish what they were intended to and more importantly, that they are not cost effective.

Congress is beginning to understand that the business of health is so diverse and so individualized that regulations designed for health must be on the basis of experience. The number of exceptions approaches the number of services provided.

Health has not been alone in its plea for relief. A steady stream of lobbyists brings the same message. Some are gaining ground. The airline deregulation and trucking deregulation proposals both saw passage this year but neither proposal sailed through Congress. The effects will be watched carefully. The airline industry has been wrenched. The big ones are losing and the upstarts are doing well. It remains to be seen if the public is better served.

The Federal Trade Commission nearly died this year. No government agency so represents regulation as the FTC. Congress usually enjoys taking shots at agencies because as one senator put it, "they're big, slow moving, and when you hit them, they bleed a lot." What began this year as a traditional hearing purge, however, wound up with stiff legislation and expired appropriations.

This mood, coupled with shrinking federal coffers, explains the interest in alternatives to more government. Congress has been serious about a balanced budget, at least until the politics of an election year tax cut take hold. There is no interest in new federal social programs, no interest in expansion of existing programs, and great interest in more for the dollar and any

proposal which intends to do that.

Still, while there may be enthusiasm about cutting loose nuts and bolts industry, there is real concern about just letting health care float to where the market will take it. Such will never occur. Some regulation, control, and legislation will always be a part of health care.

**Areas of change**

There are two areas where change might occur to spur competition in health care. The first looks at the folly of cost based reimbursement. This invention of medicare probably accounts for a large part of the escalation of costs. When you are paid whatever it costs there is little incentive to be prudent, efficient, or competitive.

The second tether on cost consciousness can be found in the tax laws. Under present law, the amount paid by an employer to a health plan for an employee is not includible in the employee's gross income for the purposes of income tax. Further, a deduction is allowed to an employer for compensation paid to employees in the form of contributions to a health plan. This makes health a "best buy" for the employee without much complaint from the employer since he too can deduct it.

Not surprisingly then, procompetition measures introduced into the House and Senate focus on these two areas. In June of this year the most ambitious of these bills was introduced by Richard Gephardt (D-Missouri) and Dave Stockman (R-Michigan), two acknowledged bright stars in the House of Representatives. The National Health Care Reform Act, HR 7527, revises the tax code, calls for phasing out medicare and medicaid by substituting vouchers to be used for purchasing private health plans, equalizes medicaid benefits, provides for the availability of private plans for the currently uncovered, abolishes health systems agencies and PSROs, and encourages innovations in alliances between providers and insurers.

This bill will not pass. It will provide a new focus for discussion and give much foundation around which less global pieces might be sequentially tackled.

Not many people know what competition in health care would really be like. There are many unknowns in the equation. It will not be a free hands-off affair as many colleagues might wish. It could be traumatic with some great changes in the financial affairs of medicine. Tax laws and cost based reimbursement will change. The Health Care Financing Administration is right now looking to experimental bid ventures. The prospect of fewer regulations, greater efficiencies, services to the unserved, and less scorn because of costs appeals to us all.

**Conclusion**

We have the chance to be positive for a change. Organized medicine's image in Washington is that of negativism and reaction. We have not been viewed as innovators or great proponents of national health and well being. We have been more often opposed to than supportive of legislative initiatives.

Perhaps now there exists a growing consensus of how best to provide for our brothers and sisters. If we develop a congressional alliance to accomplish this we will all be well served.


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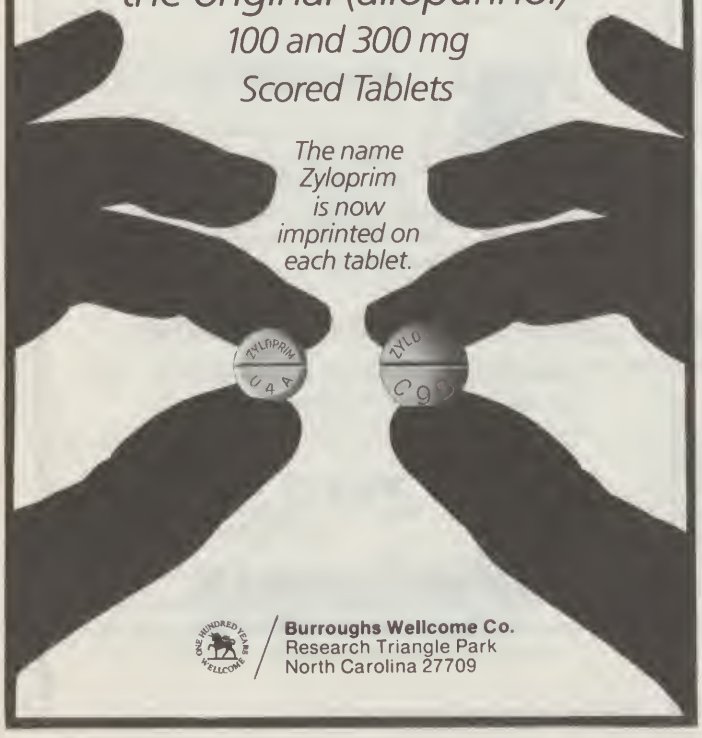


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# physicians in the news

The Pennsylvania Chapter of the American College of Emergency Physicians recently elected **John R. Paluso, MD,** Washington, president. Others elected are **Drs. Roland T. Keddie,** Pittsburgh, vice president; **William O. Robinson,** Pittsburgh, secretary; **Jesse A. Weigel,** Harrisburg, treasurer; and **John W. Becher,** West Chester, member-at-large.

**Murray G. Mitts, MD,** a neurosurgeon with four advanced degrees, is the new deputy for operations of the Veterans Administration's health care system. Dr. Mitts earned his master's and PhD degrees at the University of Pittsburgh.

**William C. Menzies, Jr., MD,** a staff physician at United Community Hospital, recently was named the 1980 recipient of the A.G. Sikorsky Award for exceptional teaching. Dr. Menzies has participated in the Western Pennsylvania Preceptorship program for 15 years.

The American Medical Association recently appointed **W. Richard Kneller, PhD,** to a three-year term on its National Committee for Member Society Development. Dr. Kneller is executive director of Lackawanna County Medical Society.

**Thomas J. Martin, MD,** Danville, recently was elected chairman of the Pennsylvania Chapter of the American Academy of Pediatrics. Other officers are **Drs. Thomas P. Gessner,** Latrobe, alternate chairman; and **Harvey M. Rubin,** Pittsburgh, secretary treasurer. **Susan Aronson, MD,** Narberth, and **Richard K. Lanz, MD,** Pittsburgh, were elected to the executive committee.

**Thomas E. Strax, MD,** recently has been named president elect of the Pennsylvania Academy of Physical Medicine and Rehabilitation. Dr. Strax, who has cerebral palsy, is assistant medical director of Moss Rehabilitation Hospital, Philadelphia. He was named Handicapped Pennsylvanian of the Year in 1973.

The National Medical Association named **Theodore L. Yarboro, MD,** its Practitioner of the Year at its 85th annual convention in Dallas. Dr. Yarboro has been in family practice in Sharon since 1965 and is a member of the medical staff at Sharon General Hospital.

The Shenango Valley Jaycees named him Man of the Year in 1972 and in 1980 he was selected to "Who's Who Among Black Americans."

He is a member of the PMS Council on Education and Science and is chairman of the PMS Commission on Education and Manpower.

**Stanley C. Ushinski, MD,** recently was elected president of the Pennsylvania Allergy Association. Dr. Ushinski also is president of the Luzerne County Medical Society. He is clinical assistant professor of pediatrics at Hahnemann Medical College, visiting instructor in pharmacology at the Medical College of Pennsylvania, and head of the allergy clinic at the Wilkes-Barre Veterans Administration Hospital.

**Joseph A. Weader, MD,** has been named assistant to the medical director at Geisinger Medical Center. Dr. Weader is director of the general pediatrics and neonatology department at Geisinger.

**Harry Gottlieb, MD,** Lafayette Hill, has been elected to the Board of Corporators of the Medical College of Pennsylvania. Dr. Gottlieb is professor of medicine and president of the medical staff at the college. He is past president of the Philadelphia Endocrine Society.

Newly elected officers of Thomas Jefferson University Hospital's staff are **Drs. John Y. Templeton, III,** president; **Jay J. Jacoby,** vice president; and **John M. Fenlin, Jr.,** secretary treasurer. Dr. Templeton is chairman of the PMS Constitution and Bylaws Committee.

**Carol N. Maurer, MD,** recently was elected president of the Oil City Hospital medical staff. Other officers are **Drs. Nicholas J. Possa,** vice president; and **Theodore R. Treiber,** secretary treasurer. Dr. Maurer is a member of the PMS Board of Trustees.

The Hershey-Palmyra Sertoma Club recently presented its Service to Mankind Award to **D. Lee Backenstose, MD.** A family practice physician in Hershey for 28 years, Dr. Backenstose is medical director for the Milton S. Hershey School.

**Joseph A. Marasco, Jr., MD,** is the 1980-81 president of the Pennsylvania Radiological Society. **Robert E. Campbell, MD,** is president elect; **Robert E. Farrell, MD,** is secretary; and **Ronald Clearfield, MD,** is treasurer.

**Warfield Garson, MD,** Mount Lebanon, recently took office as president of the Pennsylvania Public Health Association. Dr. Garson is medical director of Consolidation Coal Company, Pittsburgh.

Retired Brigadier General **John B. Coates, Jr., MD,** recently was elected surgeon of the Department of Pennsylvania Veterans of Foreign Wars. Dr. Coates also serves the VFW as surgeon general of the national organization.

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Orderly recruiting and hiring of lay employees is one need which is a recurrent theme in our surveys of medical practices. If conscientiously approached, there is little excuse or reason for less than a competent, personable staff.

Despite obvious benefits, no other single element of personnel management is given such short shrift as the initial processes involved in hiring. Too often the recruiting process is a haphazard effort turning up a few applicants and perhaps selecting the best of a bad lot.

There should be a specific, prearranged routine for employing any new assistant. Shortcutting the process should be avoided no matter how promising an applicant's first impression. Once developed, the routine should be set down in writing to guide future hiring searches.

### Creating applicant pool

The first step in this routine must involve the question of where to look. The specific answer will vary from place to place, but generally, the best answer is to try all available approaches. A superstar could turn up anywhere and by creating the largest pool of possibilities, the chances of finding the right person are increased.

Placing ads in both weekly and daily area newspapers is one obvious step. There are, however, great variations in want ad success levels depending on how those ads are drafted. A few simple steps can improve dramatically the number of responses received.

The ad must be eye-catching. This is accomplished easily enough by making the ad larger than minimum size, placing a border around the ad, or similar measures. Although they may cost more, such announcements more than pay their way by improving chances that the ideal employee will respond.

The practice should be described in appealing terms so that the reader will want to find out more. A busy, growing family practice can describe itself as such. An office taking pride in its level of employee morale can say so. Almost any reader comparing such an ad with the usual "med. sec. - exp. nec." is far more likely to respond.

Third, the job opening should be described broadly to encourage inquiries. Remember that you are trying to create the largest pool possible and not screen out any possible applicant at this point. For example, the words "secretary in medical office" are better than "medical secretary" since the latter term implies some special preexisting skills. Most good secretaries can adapt easily to the medical practice aspects in a short time on the job if they have the other desirable qualities.

Lastly, an ad should not quote salary. Unless a practice follows prescribed salary classifications or job grades, pay levels should remain flexible. The practice should be willing to pay whatever is within reason to attract the best employee. Losing a top-flight person for an extra $5 per week is a false economy.

Employment agencies, junior colleges, and medical assistant schools are other potential sources of applicants. Many of these sources, however, do not screen applicants before recommending them. Thus the persons sent out often seem ill-suited for the position. With that in mind, it is essential that all applicants, regardless of source, be screened extensively.

The sometimes successful source of "piracy," offering employment to a person already employed at a local hospital or at another medical office, is equally often a mistake. Physicians often presume that aides they occasionally see in other offices would be ideal for their private offices. Unfortunately, many of those persons can not handle a job change. Again, it is essential that all applicants be tested according to the same criteria. Too often, a little personal knowledge of the applicant is a dangerous thing.

### Screening applicants

Consultants differ whether it is best to screen applicants initially over the telephone or by reviewing resumes. Each has its advantages. We prefer using the telephone, but we cannot find fault with the resume process.

Telephone screening gives the doctor or office manager the opportunity to test an applicant's ability to handle telephone conversations. This cannot be accomplished by looking at a resume.

We also find that the telephone screening often is easier to handle since it may be scheduled at the doctor's or office manager's convenience and it takes less time than reading resumes. On the other hand, resumes may be reviewed at leisure and not during regular practice hours. Furthermore, having resumes mailed to a post office box conceals the identity of the prospective employer which may

*The authors are the principle consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, PA.*

be desirable in some circumstances.

Assuming that the telephone screening route is followed, the person handling the screening process should have a specific list of questions to be asked. A checklist also should be ready, at least mentally, by which to decide whether to invite the applicant to the office for an interview.

Having the screening and many of the later functions handled by aides is important for several reasons. First, of course, the physicians in the office should be spared administrative details as a matter of time and efficiency.

As important as the cost effective use of physician time, however, is the need to involve existing employees in the hiring process. Quite simply, the present office staff has more at stake in the selection process than do the doctors. Other staff will have to work closely with a new employee. This makes the personality mesh more important than the initial technical skills. The aide eventually hired probably will be most valuable if the rest of the staff is accepting and helpful. Involvement in the initial hiring process most often encourages such a response.

**Initial interviews**

Those persons selected to come into the office for an initial interview should be scheduled to meet with one or more of the staff and preferably not with the doctors. This is an extension of the two principles of saving doctor time and involving the staff.

While the office manager or senior assistant who did the telephone screening should conduct the interview, we would urge that other staff be brought in as well. This allows more of the aides to evaluate the applicant from a personality standpoint and also offers the applicant a better feeling of the office environment.

The initial interview should begin by having the applicant complete an employment application. A preprinted form including both specific, routine questions (personal history, job history, health history, education, etc.) as well as more general questions should be used. This preliminary information gives the interviewer good leads for further questions and items of discussion during the interview.

Since we particularly urge checking references with prior employers, the form should inquire as to why the applicant left the prior jobs, what was liked or disliked about them, and the applicant's salary history. Comparing these responses with the prior employers' views is a test of the applicant's honesty as well as employment history.

Regardless of the form used or questions asked, the applicants should be required to complete the form in their own handwriting. Neatness and legibility should be desired qualities of all staff persons. For example, a receptionst will have to fill in the appointment book carefully despite many distractions. An insurance clerk may complete some forms and reports by hand when it is most convenient. A clinical assistant might record information on procedures and that report will become part of the medical record. Sloppy handwriting certainly can hamper the effectiveness of all such work and thus it should be tested during the recruiting process.

Another question which should appear on the application form is the person's salary expectation. No more than a broad salary range should be stated in reply to the applicant's direct question (perhaps over the phone) so that a proposed salary figure first would have been specified by the applicant (on the form) rather than by the employer. This has obvious advantages.

The interview itself should be a two-way matter. The senior aide(s) should find out about the applicant's experiences, how qualified the applicant is for the job in question, and also ask general questions to develop a feeling for the applicant as a person. At the same time, the applicant should be encouraged to inquire about the job, the hours, working conditions and characteristics, the nature of the practice, and so forth. The applicant is as much evaluating the job as the practice personnel are evaluating the applicant.

**Skill testing**

Some applicants may claim greater skills than they actually can demonstrate. For example, an applicant who claims to type at 70 w.p.m. may type more slowly or may type that fast only at the expense of neatness and accuracy. Similarly, some experienced bookkeepers have difficulty balancing a simple one-page check register.

Once an office hires an aide, it may be difficult for it to function properly when the aide's capabilities do not match the office's expectations. The office may find itself stuck with a marginally satisfactory employee. To avoid such disappointments, have the staff find out what the applicant's skills really are.

Thus we recommend that a prac-

tice's hiring procedure call for skill testing whenever possible. Typing capabilities require a simple five minute dictated tape (reasonably free of practice terminology) to be transcribed or a one page letter to be typed as copywork. Bookkeeping, receptionist, and medical assistants jobs require greater ingenuity in the design of "homemade" skill tests. Still they can be designed with some degree of usefulness. One approach that works is to ask the present staff to develop such tests.

A further extension of the skill testing idea is to require the applicant to respond to particular "word problems" that are likely to demonstrate the ability to handle the problems or difficult incidents of the job. There are no "right" answers, but the interviewer may get some insight into the applicant's common sense and decision-making abilities.

Skill testing in general serves two important hiring functions. First it helps assure the practice that employees have the basic level of competence required for their jobs. Secondly, the tests help determine whether applicants are reliable. Those who exaggerate their measurable job capabilities generally are not desirable employees. For both of these reasons, the skill test is a simple and valuable device.

**Physician interview**

After a number of initial applicants have been screened, tested, and interviewed by the responsible aides, the physician (or the managing physician of a group practice) should meet with those aides for a review session. The staff then openly recommends a few applicants for follow up interviews with the doctor. Although the doctor may properly inquire into the rejected applicants and the reasons for the aides' decisions, only in rare instances should the doctor overrule them. The aides will have to work with any newly hired employee even more closely than the doctor will.

The second interview should be conducted primarily by the physician but it should be open to attendance by the other staff. At least one or two aides involved in the earlier work should attend. There is nothing to hide in the interview and a second look at a prospective applicant may reveal more to the staff than the first interview.

A variety of subjects need to be covered in the interview with the doctor. The doctor should draw all applicants into discussing their suitability for the position. Particular attention should be paid to their descriptions of previous employers, what was liked or disliked about the jobs, and why they left those positions. These comments can be compared with the answers on the application form and also with the comments obtained during the reference checking routine.

The doctor also must be sure that the job and all personnel policies are described clearly to the applicant and that all questions are answered. This would include stating an initial salary offer which has been decided upon in advance. No actual job offer should be made during this interview; however, the details should be discussed to determine if they probably would be acceptable if the applicant is chosen. We think that this rule should be followed even when one applicant seems to be the perfect choice.

Courtesy and continued involvement of the aides demand that the doctor review the decision with them, thus attempting to make the decision a joint one. In this way, even when the aides disagree and the doctor's preference prevails, they at least will have the satisfaction of knowing that their opinions were sought and considered. In all cases, references should be checked before hiring and the time most suited for this is after the interview with the doctor.

**Reference check**

It should be an absolute rule that an applicant will not be hired without checking references. At least the immediate prior employer and often the one before that should be contacted. This check should be made by telephone, never by mail and we usually find that a "peer to peer" telephone call works best. If the person named as the prior supervisor is a doctor or executive, the doctor should make the inquiry. If the person listed is an office manager or the near equivalent, the office manager should call. With this approach, the individual called tends to be more candid and perhaps less guarded.

The reasons for telephone checking should be obvious. A previous or current employer is often and understandably unwilling to state something unfavorable in writing. By telephone, the reference checkers can detect hesitations, inflections, and the like which may lead them to explore certain responses further.

A list of specific questions should be on hand for conducting the reference check. Such questions might include the following: What were the person's jobs and duties? Were those duties performed satisfactorily? Were work habits satisfactory? Was absenteeism a problem? Did this person handle money?

Find out what the person did best and worst; final salary; and reasons for leaving. Ask if the employer would rehire the person. Additionally, questions to be compared with the responses on the applicant's employment application should be pursued. Any answer not wholly satisfactory should be followed up by more questions.

The reference check will not guarantee a successful employee decision, but it is the one chance of getting some advance ideas of how an applicant actually may perform on the job. The call rarely will take more than a couple of minutes and the value of reducing the chances of making a hiring mistake is tremendous.

**Conclusion**

If the reference check on the selected person has been satisfactory, the applicant then should be offered the job on the terms discussed at the second interview. Assuming the position is filled, the other applicants should be notified with thanks. Their applications should be kept on file since the interview process may have branded one or more of them as excellent candidates should another job open in your office.

The entire process may appear time consuming for a small medical practice, but it is most certainly time well spent. The physician-time, however, should be kept to a minimum despite the thoroughness of the effort. The theme during the hiring routine should have been on staff involvement to emphasize that a compatible group of employees are most likely to create the best office.

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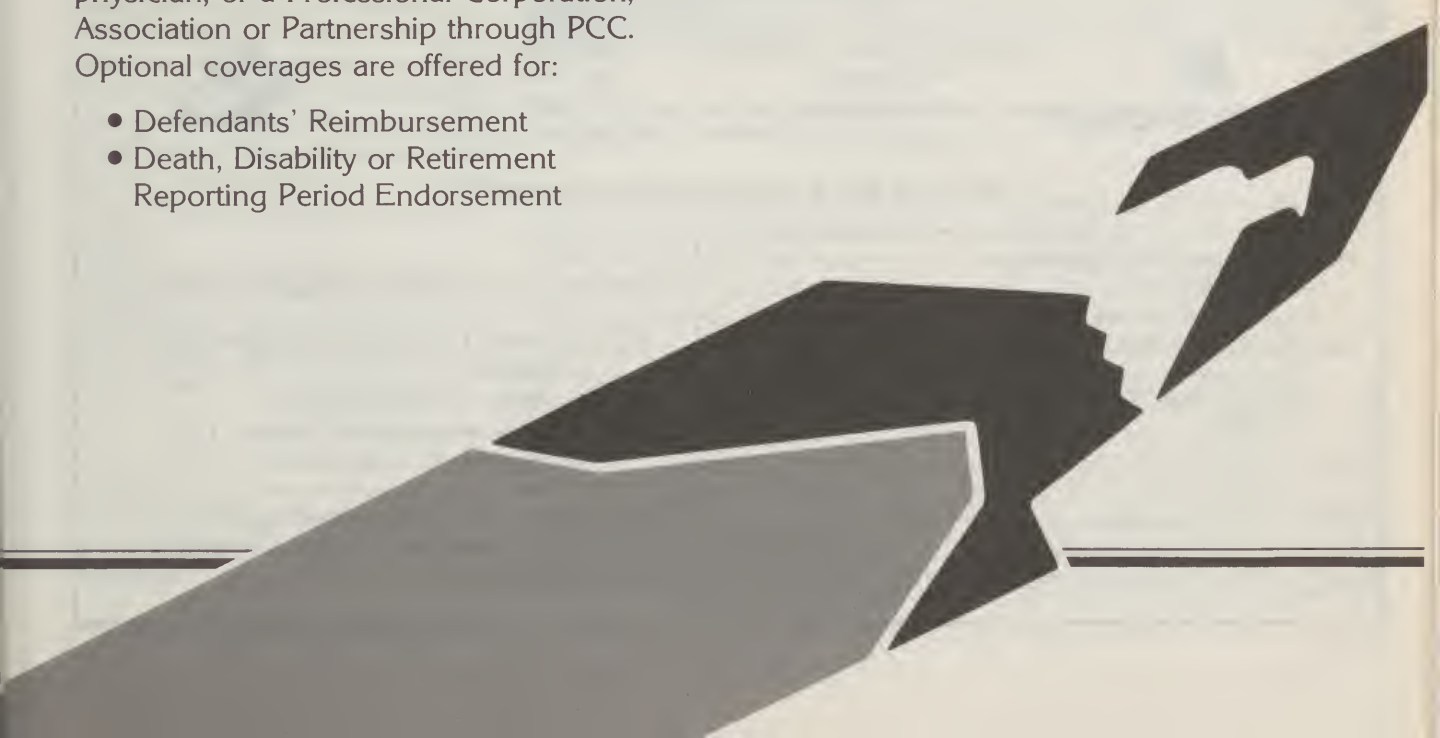

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Case report

# Incomplete or reversible pulmonary infarction

Jacob Zatuchni, MD

Lung infiltrates from pulmonary embolism may be due to hemorrhage or infarction.[1] The first are referred to as incomplete, and the second as complete infarctions. The difference between the two types is necrosis of alveolar walls.[2]

An incomplete infarction is transient and leaves no trace. A complete infarction lasts weeks or months and heals by organization and fibrosis.

In this report, an incomplete pulmonary infarction was manifested by pulmonary congestion which was unmasked by roentgenogram in the lateral projection. Its rapid disappearance could have been due to dissolution of pulmonary embolism demonstrated by lung scan.

## Case report

A 63-year-old man was admitted to Episcopal Hospital on February 22, 1978, with shortness of breath which occurred after shovelling snow two weeks earlier. The shortness of breath persisted with increasing severity for the three days prior to admission. On the day of admission he experienced mild tightness of his central anterior chest.

Clinical examination revealed normal sinus rhythm and no murmurs. Shortly later, atrial fibrillation occurred. Blood pressure was 190/110 mm Hg and temperature was 99° F.

*Figure 1.* **Chest roentgenogram on admission showing pulmonary congestion and increased size of cardiac silhouette.**

A chest x-ray taken in the anterior projection showed a cardiac silhouette of increased size with prominent pulmonary vascular markings compatible with congestion (Fig. 1).

Electrocardiogram showed atrial fibrillation with left axis deviation of QRS to −15° posteriorly with increased voltage compatible with left ventricular hypertrophy. ST-T abnormality suggested ischemia.

The diagnosis was heart failure and possible myocardial infarction. The patient received Digoxin and Lasix with consequent diuresis and lessening of dyspnea.

Shortly after admission, chest x-rays obtained in both lateral and posterior-anterior projections demonstrated bilateral hydrothorax and a Hampton's hump arising from the left posterior costophrenic sulcus (Fig. 2).

Laboratory studies showed a leukocytosis of 12,800/mm$^3$, respiratory alkalosis, and mild hypoxemia. Lactic dehydrogenase was 355 m$\mu$ml, bilirubin 1.2 mg%, and serum glutamic oxalotransaminase 50 m$\mu$/ml. Serial

*Dr. Zatuchni is director of the department of medicine at Episcopal Hospital and professor of medicine at Temple University School of Medicine.*

*Figure 2.* **Chest roentgenograms in P-A and left lateral projections. Note bilateral hydrothorax and Hampton's hump arising from left posterior costophrenic sulcus.**

*Figure 3.* **Chest roentgenogram in P-A and left lateral projection 48 hours after that shown in Fig. 2. Note clearing of pleuropulmonary abnormality and normal size of cardiac silhouette.**

transaminase and electrocardiogram showed no significant change.

The patient received Heparin intravenously, 10,000 units every four hours for six doses and every six hours thereafter.

Chest x-ray in 48 hours showed complete clearing of pleuro-pulmonary abnormalities and a normal size cardiac silhouette (Fig. 3).

Lung scan, performed four days after admission, was negative.

On the eighth day after admission, normal sinus rhythm returned. The patient was discharged two days later. He felt well and his physical and roentgenographic findings were negative.

## Discussion

The diagnosis of pulmonary infarction depended on the roentgenographic demonstration of so-called "Hampton's hump."[3] Hampton and Castleman reported that pulmonary infarcts always are located peripherally and they involve one or more pleural surfaces with a "hump"-shaped convexity at the proximal edge.[2]

They stated that the medial or cardiac margin of an infarct is convex toward the heart and presents a serrated margin. When the central roentgen ray is tangent to it, a convex, slightly irregular "hump"-shaped shadow is produced. They cautioned that such a shadow is seen only in the posterior-anterior projection when the lateral sulci are involved, and in the lateral projection when the anterior or posterior costophrenic sulcus is involved. Therefore, they emphasized the need to obtain multiple projections of the chest.

In the case reported, what seemed to be pulmonary congestion due to heart failure actually was pulmonary infarction. The diagnosis could not be made using the anterior projection; it had to be established by the demonstration of Hampton's hump in the lateral projection.

The lung infiltrate or lack of it in pulmonary embolism depends upon the size of the vessel involved, the capacity of the distal vessels to contain diverted bronchial arterial blood, and the adequacy of pulmonary arterial outflow.[1] The presence of lung disease or chronic heart disease favors diapedesis of red blood cells because of intrinsic structural abnormality or increase in pulmonary venous pressure.

Additionally, as in this reported case of an incomplete infarction, rapid dissolution of the occlusion may be demonstrated by a normal lung scan within days of the onset of pulmonary embolism which was severe enough to produce apparent heart failure. The lung scan in pulmonary infarction characteristically reveals a perfusion defect which persists for weeks or months.[4] The longer the duration of abnormality, the greater the likelihood of underlying disease. For these reasons, a hemorrhagic or incomplete and reversible infarction is more likely to occur in healthy patients. As Fleischner stated, the classical or complete infarction is the exception in surviving patients.[3]

Yet both types of infarction are due to pulmonary embolism and may produce indistinguishable symptoms and signs. Masquerading manifestations such as heart failure or syncope also may be demonstrated.[5] For these reasons and because of the embolism's transient presence, it may be difficult to diagnose incomplete pulmonary infarction or to demonstrate the lesion by a limited roentgenographic study.

## REFERENCES


1. **Dalen, J.E., Haffajee, C.I., Alpert, J.S., et al.:** Pulmonary embolism, pulmonary hemorrhage and pulmonary infarction. *New Eng J Med 296:*1431-1435, 1977.
2. **Hampton, A.O. and Castleman, B.:** Correlation of postmortem chest teleroentgenograms with autopsy findings with special reference to pulmonary embolism and infarction. *Amer J Roentgen & Radium Therapy 43:*305-326, 1940.
3. **Fleischner, F.G.:** Pulmonary embolism. *Clin Radiol 13:*169-182, 1962.
4. **Paraskos, J.A., Adelstein, S.J., Smith, R.E., et al.:** Late prognosis of acute pulmonary embolism. *New Eng J Med 289:*55-58, 1973.
5. **Thames, M.D., Alpert, J.S. and Dalen, J.E.:** Syncope in patients with pulmonary embolism. *JAMA 238:*2509-2511, 1977.

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# Sexual dysfunction evaluated in sleep labs

**Ralph E. Fishkin, DO**

Modern sleep research burgeoned in 1953 with the discovery of REM state and its association with dreaming by a University of Chicago graduate student named Aserinsky. Since that time, interest in examining physiological measurements during sleep has been intense.

REM periods were shown to accompany a general increase in autonomic activity including heart rate, respiration rate, and systolic blood pressure, and that REM onset is marked by increased variability in these activities.[1] Aserinsky also noted that erections during sleep, described as early as 1940 by Halverson, closely paralleled the REM state in their occurrence and duration.[2] The development of a valid, reliable transducer enabled Karacan and Fisher to document this.

The transducer was a mercury strain gauge. In essence, the gauge is a fine-bore rubber or plastic tube filled with mercury. It encircles the penis. With erection, the tube stretches, causing the mercury column to contract; a mathematically related increase in the resistance of the mercury occurs simultaneously. This is amplified and recorded on the polygraph.[3]

**Normative data**

By 1976, Karacan and his associates[4] reported the completed results of a systematic exploration of nocturnal penile tumescence, or NPT, in men of all age groups. The study was undertaken to examine the NPT phenomenon and to provide norms which would be useful in assessing the diagnostic and prognostic value of NPT determinations in a variety of clinical conditions.

The researchers showed that NPT is a phenomenon which occurs in all age groups. It is mostly associated with the REM period. A small percentage of NPT is associated with the NREM phases of sleep, particularly in the prepubertal and pubertal years when sexual maturation is occurring, and in the late 60s and 70s when the amount of time men spend in REM begins to decrease.

NPT peaks at 3-5 years and again between 10-19 years and then declines slightly but steadily throughout life. The typical NPT episode begins every 72-100 minutes, just before or just after the onset of REM. It usually exceeds the length of the REM period, lasting for 20-30 minutes, though it is not unusual for NPT episodes to last for more than an hour. Men in their 20s average about four erections a night, while men in their 70s experience three or less.

Not all NPT episodes are full erections. Men in their 20s have a mean of 0.72 partial erections a night, while men in their 70s have a mean of 1.29 partial erections a night. For older men, the length of time that each maximum erection remains full decreases.

The ability to graph erections accurately in the lab afforded the opportunity to examine the erection process more closely. Penile erectile activity can be divided into three phases, designated by Karacan as T-up, T-max, and T-down. The percentage of time spent in each of these phases during maximum NPT episodes also varies according to age.[5,6]

Younger men become fully erect, (T-up), more quickly than older men. They generally stay erect, (T-max), for twice the time it takes them to become more fully erect. Men in their 60s take almost twice as long to become fully erect as men in their 20s, but they only stay fully erect half as long. The T-down phase is roughly the same percentage of total erection across all age groups.

Another observable feature of the erectile process which helps to differ-

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*Dr. Fishkin is clinical assistant professor of psychiatry and human behavior at Thomas Jefferson University.* *This is the ninth article prepared under the supervision of Thomas Wolman, MD, and the department of psychiatry at Jefferson as part of the series on office counseling for primary care physicians. The series is a project of the departments of psychiatry of the state's seven medical schools in cooperation with the Pennsylvania Psychiatric Society.*

entiate normal from abnormal erections is the presence of pulsations in the T-up phase of the erection. These pulsations can be clearly seen when the polygraph is running at 10-15 mm/minute. They reflect the vascular component of the erectile process in which the penis becomes distended with blood due to the opening of anastomoses between the arterioles and the vascular spaces in the corpora cavernosa.[7] The absence of these pulsations, or the failure of the penis to increase in circumference with each pulsation, suggests the possibility of vascular insufficiency, or fibrosis of the erectile tissues which often occurs after prolonged priapism.

**Organic causes of impotence**

Armed with these new data about the physiology of erections, researchers turned their attention to differentiating between organic and psychogenic impotence. Traditionally, psychogenic impotence was considered to account for 85-90 percent of all impotence.

We are now able to detect and confirm organic deficits in a variety of clinical states. These include: cardiovascular conditions such as arteriosclerosis, both diffuse as well as localized; endocrine disorders such as pituitary tumors, Cushings and Addison's Disease, diabetes, thyroid hyper- or hypofunction, and hypogonadism; genitourinary conditions such as priapism, Peyronie's disease, mumps, and penile trauma; hematological conditions such as anemia, Hodgkin's Disease, and leukemia; neurological disorders such as herniated disc, multiple sclerosis, neuropathy, Parkinsonism, and trauma to the spinal cord; and medications, including a variety of antihypertensive drugs, psychoactive drugs, drugs of abuse, and anticholinergics.[1]

The monitoring of NPT does not replace a careful medical and psychiatric history, a thorough physical examination, and the selection of appropriate lab tests. Rather it augments these basic procedures and points the way for more specific diagnostic efforts when the etiology is doubtful.

**NPT monitoring procedure**

Monitoring of NPT takes place on three successive nights. Occasionally, only one or two nights are necessary to detect maximal erections.

The patient reports to the lab an hour or two prior to his usual bedtime. Electrodes for monitoring EEG, EMG, and eye movements are attached to the face and scalp with collodion or special adhesive. Two strain gauges are placed around the penis, one at the base, and the other on the distal shaft, about an inch from the glans. A polaroid photograph is taken of the flaccid penis.

The patient then retires to an electrically shielded private room. He remains in bed until his usual arising time or usually no longer than seven hours. When he awakens, he is free to go about his usual daily activities until the next evening. During the evaluation period, the patient is asked to refrain from alcohol, naps, and any nonessential medication.[1]

The first night is usually a night of adjustment. Both sleep and NPT patterns may be atypical in some people because of a first night effect. This sometimes is not the case and we may see maximum erections on the first night.

The second night provides basic data on NPT following the viewing of a film depicting heterosexual intercourse between two attractive, relaxed, caring partners. Most patients describe the film as mildly stimulating.

On the third night, the patient is awakened during a representative maximal NPT episode so another photograph can be taken. At that time, both the patient and the technician estimate the degree of erection on a scale of 0-100 percent. The patient also is asked to report any dream he may just have had. These procedures usually take less than 30 seconds, nonetheless, some detumescence occurs in highly anxious individuals.

**Interpretation of data**

There is no standardized method for

differentiating partial from maximal NPT. Karacan uses a rather primitive device to calculate the "buckling" pressure of the penis—the number of mm of Hg applied to the tip of the erect penis necessary to produce buckling of the shaft.[8] He uses this value in conjunction with the NPT data for differentiating organic from psychogenic impotence. Fisher[9] uses another method—comparing the patient's and the technician's estimate of the maximal erection obtainable upon masturbation with the data derived from the NPT study.

Both methods are inexact. The major difficulties encountered are the rapid detumescence which often occurs in psychogenic impotence, and the imprecision involved in estimating percentage of full erection by direct observation, even when the observer has had extensive experience. Despite these difficulties, the procedure is superior to our previous diagnostic methods in that we can observe the erectile pattern over several nights and we can gather data about the frequency, duration, and form, as well as, the expansion characteristics of the patient's erections.

Karacan is evaluating several devices which take rigidity readings during NPT episodes and which obviate the necessity of awakening the patient. Ultimately, he expects these devices to replace the strain gauge.[8]

On occasion, additional procedures are necessary to characterize deficits in NPT. One of these is calculating the penile blood pressure by using the Doppler ultrasound technique. Penile blood pressure is compared with brachial blood pressure to detect significant alterations in blood supply to the penis.[10]

Another sleep laboratory procedure which may be useful in pinpointing erectile dysfunction related to neuropathy is monitoring EMG activity in the bulbocavernosus and the ischiocavernosus muscles. In the normal male, there are bursts of activity in these muscles just prior to the appearance of the vascular pulsations detected by the strain gauges. Karacan[8] has shown that this EMG activity is absent in organic diabetics.

Both the Karacan and Fisher groups have reported several studies[8-11] showing how useful the NPT method is in differentiating organic from psychogenic impotence. In psychogenic cases, the penile circumference during NPT is different from its circumference when the patient is awake. Contrary to our previous ideas, psychogenic impotence can mimic organic impotence. It can come on gradually, and persist when the patient attempts sexual arousal with different partners, as well as during masturbation. The patient also may not be aware of nocturnal or morning erections, even though he may be having them.

On the other hand, patients who have brief full or partial erections may be unable to sustain them due to some organic factor. Their erectile dysfunction mimics our previous conception of psychogenic impotence. Sleep lab evaluation, however, reveals abnormalities in frequency or duration of their erections during NPT or disparity between expansion of the base and tip strain gauges, indicating a structural problem, such as fibrosis secondary to priapism, or Peyronie's Disease.

In Fisher's[9] recent study of 30 impotent men, sleep lab evaluation resulted in a discrepancy between initial diagnostic impressions and final diagnoses. This occurred most often in those initially diagnosed as psychogenic. Of those 14, seven were found to be organic. Of the ten thought to be organic, only one was found to be psychogenic. Of the six in the indeterminate group, three were considered finally to be organic and three psychogenic. Organic patients had a mean of 13.1 mm of expansion of the base strain gauge; psychogenic patients had a mean of 28.1 mm of expansion.

### NPT and psychological factors

Nocturnal penile tumescence is a rather stable phenomenon, most resistant to suppression of all of the physiological aspects of REM sleep, and most readily dissociated when REM is suppressed, so that it may persist maximally during NREM sleep.[4] Many, if not most REM erections appear to be nonerotic in nature. Only a minority are associated with erotic dreams.

Our patients have reported dreams about churches, dogs, or, most commonly, have not been able to recall any dreams at all. One patient who was being evaluated for impotence dreamed that the technician was awakening him to tell him that his difficulty was organic, not psychogenic, reflecting the wish he had stated in the clinical psychiatric evaluation.

Fisher[9] has postulated that erections are suppressed in psychogenic impotence as a means of avoiding psychic conflict over sexuality. The relationship between psyche and soma, however, is a complicated one. For example, while a so-called "first night effect" usually is responsible for reduction of REM, Fisher's dysfunctional patients, both organic and psychogenic, demonstrated the greatest increase in penile circumference on the first night. Perhaps for some patients the experience of coming to the lab intensifies their sexual fantasy in a neutral or nonthreatening setting, and enables them to overcome their anxiety temporarily. Several of our patients who had not been aware of erections for months reported experiencing them in the weeks following their sleep laboratory evaluations.

In 1970, Karacan and Williams[12] reported on an experiment in which several healthy married male volunteers abstained from sexual activity for a period of time equivalent to one week beyond their normal expected frequency of sexual intercourse. They found that the number of NPT episodes was lower at the end of the period of abstinence than immediately following sexual satiation.

Finally, Karacan reported that dream anxiety did interfere with the erection cycle, though in a complicated, unclear way. Sixteen young adult male volunteers slept in the lab one night a week for six weeks. EEG, eye movements, and NPT were recorded. On nights three through six, two exciting films and two neutral films were shown to each subject before he retired. The subject was allowed to sleep but was awakened five to fifteen minutes after each REM period began. Immediately after he gave his spontaneous report of the dream, he was given a mood adjective checklist to assess systematically what his feelings had been prior to awakening. The emotional content of the dreams was assessed by scoring

transcripts of the dream reports.

Analysis of the data revealed a significant relationship between anxiety as assessed in the dream transcripts and those REM periods with irregular or no erections. The relationship of anxiety on mood adjective checklist to these same REM periods was in the same direction but was not significant.

The dreams then were divided into high and low anxiety groups according to both scales. There were significant correlations between anxiety on the transcripts and depression on the checklist, leading to the conclusion that some subjects, when anxious, reported feelings of depression (sad, regretful, sorry) rather than anxiety (jittery, clutched-up, fearful). This finding may represent the activity of the defense mechanisms of the ego during both dreams and wakefulness.

Fisher[11] has reported the absence or rapid termination of erections in dreams with high anxiety. This has clinical significance for us in evaluating NPT data for patients with impotence. Both Karacan[8] and Fisher[9] have reported that 15-20 percent of their subjects showed NPT deficits in the apparent absence of organic disease. They draw opposite conclusions. Karacan stresses the possibility of covert organogenic factors but Fisher believes that at least some of these cases are psychogenic.

Fisher[9] cautions "that the method of NPT assessment, while very promising, cannot be used casually but requires considerable skill and medical knowledge." He takes issue with the proponents of portable NPT monitors, saying that "the issue is not the machine, but the fact that unless nocturnal awakenings are made during NPT episodes, evaluation may be grossly inaccurate."

This has been our experience also with the portable monitor (PTM-1 Penile Tumescence Monitor, Event Systems, Inc., Moorestown, NJ) which we used before our sleep laboratory was completed. Though these machines are well-engineered and sturdy, there are drawbacks to their use by the patient at home. Erections are difficult to evaluate visually and photographically. In the hands of patients, the gauges are fragile. We were uncertain that our patients were following our directions concerning gauge placement. These factors and our inability to correlate NPT with REM largely negated the usefulness of the tracings. We have had several patients referred to our lab because their evaluations at home had been inconclusive.

### Evaluation of women

Techniques[14,15] are now available for evaluating sexual dysfunction in women by monitoring changes in vaginal blood volume and pressure pulse during REM sleep. The vaginal photoplethysmograph is a thumb-sized plexiglas cylinder which contains a light-emitting diode and a transistorized photosensor. Light reflected from the vaginal wall is amplified and becomes an indicator of genital vasocongestion.

Abel[14] has demonstrated that this technology can reveal changes during REM. We are evaluating diabetic and nondiabetic women in our sleep lab to determine if this method can differentiate organic from psychogenic sexual dysfunction in women.

### Clinical application

Another important point to be considered is what to do with the data derived from the evaluation of NPT. In general, organic patients are referred for appropriate medical treatment or are considered to be candidates for the implantation of penile prostheses.

Psychogenic patients have the option of sex therapy, marital therapy or individual psychotherapy aimed at the underlying conflicts. Not all psychogenic patients accept their diagnoses and not all can be helped by psychotherapy. Some authorities[16] recommend implantation of a prosthesis in selected cases of refractory psychogenic impotence.

Some organic patients who refuse surgery for a variety of reasons still must learn to function sexually despite their impairment. These patients may benefit from sex therapy which may help them maximize the sexual satisfaction available to them and their spouses as they are. In some organic patients, implanting a prosthesis will not bring an automatic improvement in the patient's sexual satisfaction especially when the patient is a partner in a vitiated or conflict-ridden marriage.

In these situations the comprehensive psychiatric evaluation of the patient, his spouse, and their relationship can help to clarify the meaning of the NPT data so that the most appropriate treatment option can emerge.

### Case report

A case which illustrates this point is that of a 50-year-old man who was impotent since his early 20s. Married for 30 years, he had irregular, unsatisfactory intercourse by holding the base of his semierect penis with one hand during penetration. He estimated his degree of erection at 20 percent of full.

He was in excellent health, took no medications, and his penis was normal to examination. Testosterone, prolactin, and other lab values were normal. Evaluation in the sleep lab revealed many partial erections which we estimated at 50 to 70 percent of full.

He refused to accept the diagnosis of psychogenic impotence despite my demonstrating to him how inhibited he and his wife were in sexual matters. I reported my observation that his marriage was marked by poor communication and constant conflict over trivial matters. I also remarked on his hostility to women, and on his intense anxiety in situations, such as sex, where he was faced with loss of control.

After I informed him that I believed there was a strong psychogenic component to his difficulty, he challenged me to prove my belief. At the same time, he expressed a low opinion of psychotherapy stating, it didn't work, it took a long time, and it cost a great deal. He believed that communication was a bad thing and to support this, he recalled two brief experiences with marital therapy in which his wife cried through the sessions. Furthermore, he regarded Masters and Johnson as charlatans who either fooled people into functioning by suggestion or fooled them into being happy with their deficits.

Despite his attitudes, we began exploratory psychotherapy because although he believed his problem was organic, he did not want to have a prosthesis. Several weeks after his sleep lab evaluation, he awoke to find a full erection, which disappeared as he became aware of it. This happened

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With great reluctance, he asked his wife to join him in therapy to see if indeed he might be able to function better. He insisted that he did not want to be brainwashed, but he carried out the exercises faithfully. His wife at first was withdrawn and depressed. Gradually, they became engaged in exploring the negative aspects of their communication and of their inhibitions.

When his wife stated that she thought his erections were fuller than he thought, he attacked her and me and insisted his problem was organic. This enabled me to point out his anxiety to both of them, and how it affected their relationship. Their sexual activity gradually increased in frequency. After some time, they described their sex as "super." Through psychotherapy, he had accommodated to his partial deficit.

This case illustrates that NPT evaluations must be performed with a sensitivity as to how the data will be understood and used in the clinical context.

## Conclusion

Evaluating nocturnal penile tumescence in the sleep laboratory has made us aware that there are more men than previously thought whose impotence has an organic rather than a psychogenic basis. Disappointments from unsuccessful psychotherapy no longer are their only recourses. They now can look forward to prompt, appropriate medical or surgical treatment.

NPT also has provided a superlative opportunity to demonstrate to anxious but skeptical patients whose impotence is psychogenic that they are capable of full erections and that, for them, psychotherapy is the treatment of choice.

## REFERENCES

1. **Williams, R.L., Karacan, I.:** *Sleep Disorders, Diagnosis and Treatment.* New York, John Wiley & Sons, 1978.
2. **Karacan, I., Williams, R.L., Thornby, J., et al:** Sleep-related tumescence as a function of age. *Am J Psychiatry 132:*932-937, 1975.
3. **Rosen, R., Keefe, F.:** The measurement of human penile tumescence. *Psychophysiology 15:*366-376, 1978.
4. **Karacan, I., Salis, P., Thornby, J., et al:** The ontogeny of nocturnal penile tumescence. *Waking and Sleeping 1:*27-44, 1976.
5. **Karacan, I., Hursch, C., Williams, R.L., et al:** Some characteristics of nocturnal penile tumescence in young adults. *Arch Gen Psychiatry 26:*351-356, 1972.
6. **Karacan, I., Hursch, C., Williams, R.L.:** Some characteristics of nocturnal penile tumescence in elderly males. *J Gerontology 27:*39-45, 1972.
7. **Weiss, H.:** The physiology of human penile erection. *Ann Intern Med 76:*793-799, 1972.
8. **Karacan, I., Salis, P., Ware, J.C.:** Nocturnal penile tumescence and diagnosis in diabetic impotence. *Am J Psychiatry 135:*191-197, 1978.
9. **Fisher, C., Schiavi, R., Edwards, A., et al:** Evaluation of nocturnal penile tumescence in the differential diagnosis of impotence. *Arch Gen Psychiatry 36:*431-437, 1979.
10. **Karacan, I., Ware, J.C., Dervent B., et al:** Impotence and blood pressure in the flaccid penis: relationship to nocturnal penile tumescence. *Sleep 1:*125-132, 1978.
11. **Fisher, C., Schiavi, R., Lear, H., et al:** The assessment of nocturnal REM erection in the differential diagnosis of sexual impotence. *J Sex and Marital Therapy1:*277-289, 1975.
12. **Karacan, I., Williams, R.L., Sales, P.J.:** The effect of sexual intercourse on sleep patterns and nocturnal penile erections (Abstract). *Psychophysiology 7:*338, 1970.
13. **Karacan, I., Goodenough, D.R., Shapiro, A., et al:** Erection cycle during sleep in relation to dream anxiety. *Arch Gen Psychiatry 15:*183-189, 1966.
14. **Abel, G., Murphy, W., Becker J., et al:** Women's vaginal responses during REM sleep. *J Sex and Marital Therapy 5:*5-14, 1979.
15. **Henson, C., Rubin, H.B., Henson, D.E.:** Women's sexual arousal concurrently assessed by three genital measures. *Arch Sexual Behavior 8:*459-469, 1979.
16. **Scott, F.B., Byrd, G.J., Karacan, I.:** Erectile impotence treated with an implantable, inflatable prosthesis. *JAMA 241:*2609-2612, 1979.

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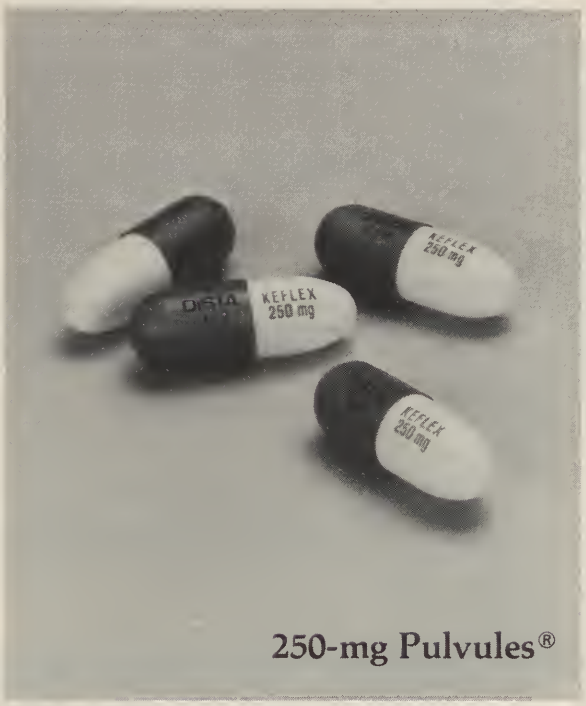


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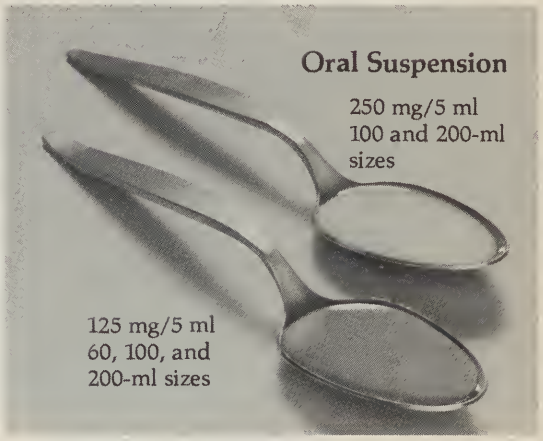

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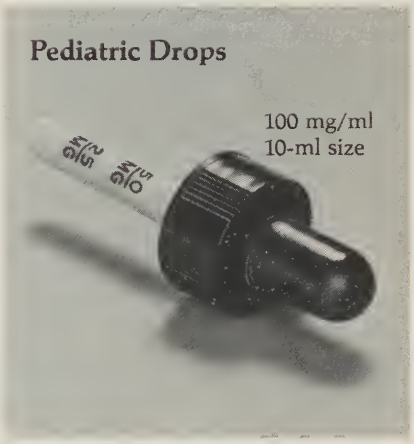

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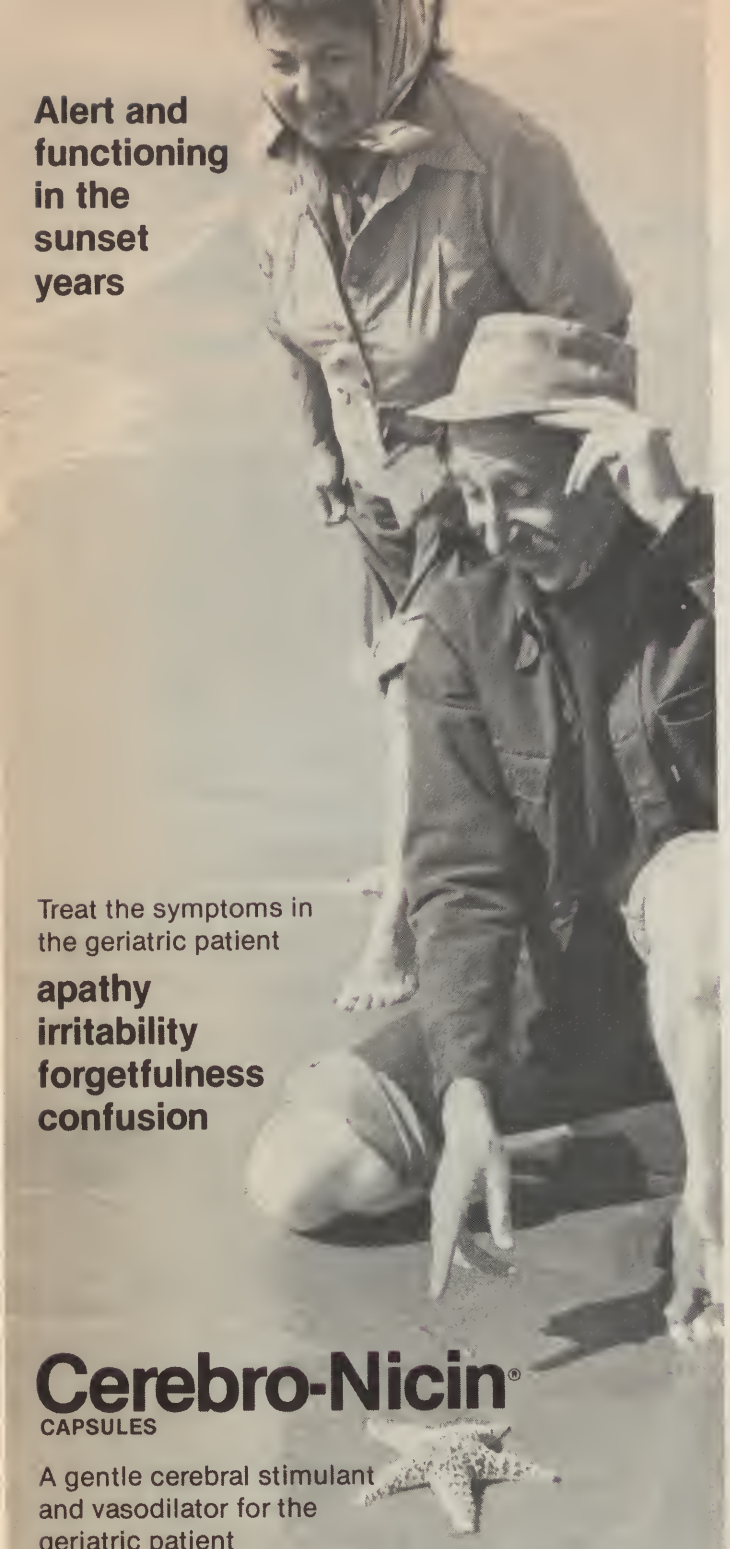

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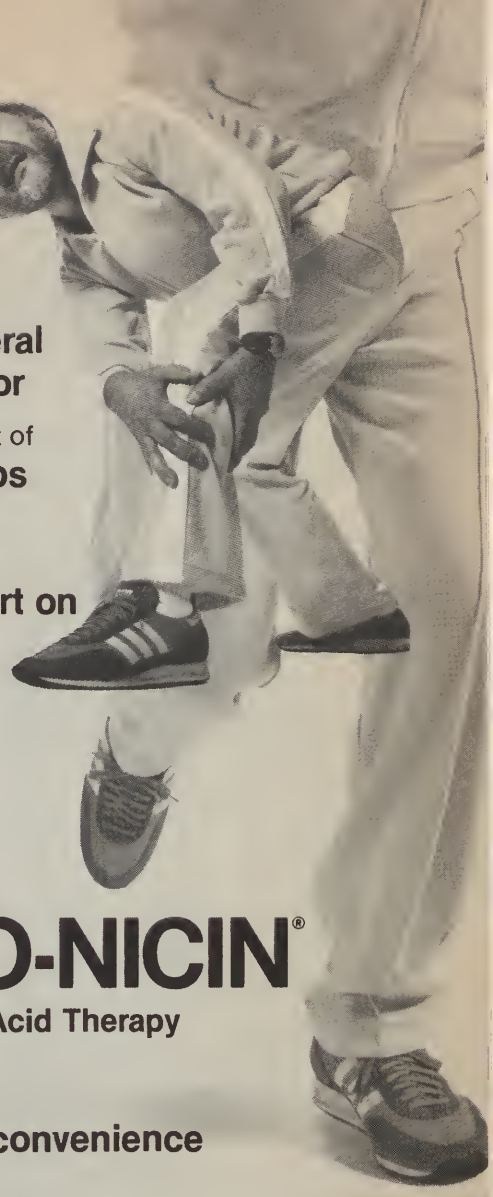

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Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
**DOSE:** 1 to 5 tablets daily.
**AVAILABLE:** Bottles of 100, 500.

**Indications:** For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

**Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

**Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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# classifieds

## PHYSICIANS WANTED

**Physician** — Anesthesiologist wanted at James C. Giuffre. Our 228-bed community hospital offers a competitive salary and fringe benefit package. Board certification is required. Contact: Deborah Baker, Personnel Department, at (215) 787-2023 or 787-2008. Or write to: Personnel Department, James C. Giuffre Medical Center, 8th St. & Girard Ave., Phila., PA 19122. Equal opportunity employer.

**Virginia** — Primary care physician needed to join staff at growing practice in scenic Central Virginia. Enjoy well equipped facility, excellent staff, strong community support, guaranteed income, excellent linkages with hospitals and other providers in area with beautiful mountains, large lakes, and year-round mild weather. Locum tenens considered. Contact: John Troidl, Administrator, Evington Medical Center, Evington, Virginia 24550.

**Family practice or internal medicine** — excellent opportunity. Immediate opening. Well-established multi-specialty group in Central Pennsylvania. Full benefits and guaranteed base salary of $48,000. Enjoy the benefits of a rural setting. One-half hour from Penn State University. Send CV to Recruiting Physician, P.O. Box 687, Philipsburg, PA 16866. Telephone (814) 342-5402.

**Physicians** — for clients in Pennsylvania and Massachusetts. Specialists in IM, FP, PD, ENT, psychiatry, physical medicine, ob-gyn, vascular surgery, orthopedic surgery, neurosurgery, and director ob-gyn. Please call E.J. Mowry, (215) 348-8700.

**General practitioner needed** — Practice in an attractive Schuylkill County farming valley, light industry community. New medical center office, equipment, start up help provided. Send resume to Reverend William Martin, Ringtown, PA 17967; (717) 889-3605.

**Large expanding community needs physician** — Large Tudor home has area for living quarters and office space, overlooking golf course and swim club. Country atmosphere midway between York and Harrisburg. Valley Green Real Estate, RD#1, Etters, PA 17319; phone (717) 938-1481.

**Pennsylvania: Western** — opportunity to assume clinical responsibilities at this moderate volume emergency department. Excellent income, flexible scheduling, and liability insurance provided. For details, send credentials to James Thomas, 230 Park Avenue, Ste. 303, New York, NY 10169, or call collect 212-599-0060.

**Anesthesiologist** — Associate, licensed in Pennsylvania. Board eligible or certified, 212 bed general hospital in Western Pennsylvania. Extremely active surgical service. Competitive compensation plus comprehensive benefit program, including liability insurance, educational leave, etc. Mail resume to Mr. Robert L. Engel, Administrator, Armstrong County Memorial Hospital, Kittanning, PA 16201.

**Family physician** — ABFP, two physician group in Northwestern suburb of Phila. (Montgomery County) seeking one (ABFP) physician. Practice utilizes 2 of finest hospitals in Phila. area. Interested in quality not volume practice. To begin Jan-July 1981. Will consider resident finishing in July 1981. Write Department 849, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

**Ophthalmologist wanted** — unlimited income. Philadelphia area. Large surgical service. Send curriculum vitae to Department 851, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

**Orthopedic surgeon wanted** — associate for well established orthopedic clinic in eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, Pennsylvania Medicine, 20 Erford Road, Lemoyne, PA 17043.

**Pediatrician and other physicians wanted** — for Bethel Park, Pennsylvania, suburb of Pittsburgh, 35,000 people. New professional building. Call (412) 833-6188.

**Director** — Family practice residency program director needed for large city located in Southeastern Pennsylvania. Excellent school system (private, parochial, public) with four major colleges. Churches of all denominations including three synagogues. Numerous indoor/outdoor recreational facilities. Hunting. Within driving distance of three major cities and Atlantic Ocean. Must have administrative experience. Excellent benefit package with office space provided. Generous salary. Call or write Durham Medical Search, 505-N Statler Office Building, Buffalo, NY 14202; (716) 852-5911.

**Physician** — Large geriatric facility is seeking a full time Pennsylvania licensed physician. Job available April 1, 1981. Forty-hour work week. Liberal salary. Very attractive maintenance free home included. Full range of benefits plus fully paid malpractice insurance. Send resume to: Walter L. Wentzel, Jr., Executive Director, Masonic Homes, Elizabethtown, PA 17022. Equal Opportunity Employer.

**Career opportunities** — Throughout Pennsylvania and from coast-to-coast for physicians in all specialties. All Fees assumed by employers. Send CV with objectives to Medical Recruitment Division, Dr. Personnel of Pittsburgh, Inc., (31 offices nationwide), 121 University Place, Pittsburgh, PA 15213, (412) 621-9975.

**Surgical technologist** — or surgical assistant (P.A.). 381 bed community hospital, N.E. section of Philadelphia, Pennsylvania. Full time; salary competitive. Contact Nazareth Hospital (215) 355-6098.

**Pennsylvania, Chester** — emergency department physician for private physician group staffing EDs in Philadelphia and Delaware County. Must be PA licensed. 40 hr. week, competitive salary, paid malpractice, liberal fringe benefits, profit sharing. Send curriculum vitae to Emergency Medical Associates, Ltd., 15th & Upland Ave., Chester, PA 19013 or call (215) 874-8177.

**Family practitioner** — to join 3 physician primary care group located in Fairless Hills, PA (NE Philadelphia suburb). Full complement of laboratory and radiology services. Hospital privileges at 2 community hospitals. Excellent opportunity for aggressive individual. Mail current CV to Medical Director, Fairless Hills Medical Center, 515 South Olds Blvd., Fairless Hills, PA 19030.

**Western Pennsylvania** — family-oriented community hospital desires additional emergency medicine residency trained physician or comparable training, experience, to complement present staff of six. Forty hour week, six week vacation, educational reimbursement, excellent benefits. Pleasant community and working environment. Approx. 36,000 visits yearly, double MD coverage during the busiest hours, compensation and benefits. 75K to 85K plus, based on training and experience. Send CV in confidence to Department 845, Pennsylvania Medicine, 20 Erford Road, Lemoyne, PA 17043.

**Obstetrician-Gynecologist** — Indiana, Pennsylvania — A beautiful university community located 60 miles north and east of Pittsburgh, PA. Indiana Hospital is a 200-bed general hospital, completing a $22 million building and renovation program, which will provide the finest in medical facilities and equipment. It is the only general hospital in Indiana County, serving a population of over 80,000. The potential for a medical practice in obstetrics and gynecology is excellent due to a strong expanding economy and a young family growth in this area which has generated the need for additional physicians in this specialty. The area has an excel-

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

## The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

## Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

**Contraindications:** Hypersensitivity to the drug.
**Precautions:** *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
**Adverse Reactions:** Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
**Dosage and Administration:** 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
**How Supplied: Hydergine tablets (for oral use) 1 mg,** packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
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lent school system, fine recreational facilities with lakes, streams, and mountain terrain for the various sports. The practice opportunity is open either for a private practice or in a partnership. Inquiries should be directed to either Richard N. Freda, MD, The Ben Franklin Medical Center, Shelley Dr., Indiana, PA 15701 (412) 463-0225 or Donald F. Smith, President, Indiana Hospital, Indiana, PA 15701 (412) 357-7120.

**Psychiatrist** — board certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact George E. Gittens, MD, Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411; (717) 586-2011.

**NEEMA Emergency Medical** — a professional association — Emergency medicine positions available with emergency physician groups throughout Pennsylvania, New York, New Jersey, Michigan, and Southeastern U.S., including all suburban, rural, and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to NEEMA Emergency Medical, Suite 400, 399 Market St., Philadelphia, PA 19106. In PA call (215) 925-3511, those outside of PA call 1-800-523-0776.

**Emergency medicine opportunities available** — Opportunities available to assume clinical and directorship responsibilities in several emergency departments located in western Pennsylvania. Excellent income, flexible scheduling, and paid professional liability insurance. Part-time opportunities also available. For details, send credentials in confidence to Mr. James Thomas, 230 Park Avenue, Suite 303, New York, New York 10169, or call collect (212) 599-0060.

**House Staff Physician** — Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $40,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Executive Director, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

**Staff psychiatrists** — positions immediately available. Our hospital is looking for psychiatrists with fresh ideas and strong convictions on public sector mental health care. We are located in pleasant, residential Northeast Philadelphia and can offer the area's unparalleled opportunities for professional growth and development. Good salary and benefits. Requirements are PA State license and board certification or eligibility. Contact, in strict confidence: Franklyn R. Clarke, MD, Superintendent, Philadelphia State Hospital, 14000 Roosevelt Blvd., Philadelphia, PA 19114; (215) 671-4101.

**Emergency physicians** — Philadelphia and suburban Philadelphia hospitals. Fee for service with minimum guarantee, 42 hr. per week avg. Experience preferred but will consider all applicants. Contact Teddy Trout (215) 438-0390 for further details or send CV to EMSS, 5555 Wissahickon Ave., Suite L6, Philadelphia, PA 19144.

**Pennsylvania Emergency Physician** — 200-bed general hospital located in western Pennsylvania university community. New modern Emergency Department. Salary highly competitive. PA license required. Contact: William B. Yeagley, MD, Director of Department of Emergency Services, Indiana Hospital, Indiana, PA 15701.

**Pennsylvania** — Emergency physician system. Needs several fulltime emergency physicians for Western Pennsylvania area emergency departments. Independent contractor arrangements. Eligible for corporate membership within two years. The system is on a "fee-for-service" basis. Contact: (412) 228-3400 for interview appointment.

**Physician placement by physicians** — unique hospital, group, and solo opportunities available in **all** specialties throughout Pennsylvania and coast-to-coast. Urban, suburban, and rural openings. Forward C.V. with your objectives in confidence to M.C. Staschak, MD, & Associates, 5th Floor - M, Manor Building, Pittsburgh, PA 15219, (412) 765-3555 (answers 24 hours).

**Family practitioners** — Tamaqua, northeast Pennsylvania. Area population about 18,000. Community assistance. Telephone collect (717) 668-1880 or write Tamaqua Area Chamber of Commerce, Tamaqua, PA 18252.


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with
## Practice Tract Program

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**Contact EMSS, Inc. (215) 438-0390 or send CV to Richard J. Murphy, MD or David K. Wagner, MD, Emergency Medical Specialty Services, Inc., 5555 Wissahickon Avenue, Suite L-6, Philadelphia, PA 19144.**


### POSITIONS WANTED

**General internist** — looking for relocation. Private practice, partnership — E.R. and private practice. Write Department 852, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Locum tenens work wanted** — Family and General Practice, open availability - T.C. Kolff, MD - (801) 566-1666.

**Internist** — 2 year practice experience, wish to relocate in South Central Pa. Looking for solo, group, or hospital base practice. Write Department 847, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

### CONTINUING EDUCATION

**Ski and Study Weeks** — Waterville Valley Primary Care Conference (January 25-30) and Sugarbush Psychiatry Conference (February 8-13). National experts. 22 CME credits. Medical Education Conferences, Dept. P, Box 2334, Providence, RI 02906; (401) 751-0001.

### MISCELLANEOUS

**Wanted** — Antique medical or surgical instruments or books. Charles Letocha, 1289 Southern Rd., York, PA 17403; (717) 846-0428.

**Physician assistants** — Become a warrant officer in the Pennsylvania Army National Guard in a unit near home. Serve one weekend a month and a fifteen (15) day annual training period each year. You will be eligible for continuing professional education, monthly pay, and a substantial noncontributory retirement plan. Enjoy the personal satisfaction of doing an important job for your state and nation. For further information contact Major Eugene P. Klynoot, Department of Military Affairs, Pennsylvania Army National Guard, Annville, PA 17003; (717) 783-3430.

**DESCRIPTION:** Methyltestosterone is 17$\beta$-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

# When **impotence** is due to androgenic deficiency.

## Android® /5 mg. Buccal/ /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

**A well absorbed oral androgen.**

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

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# obituaries

• *Indicates PMS membership at time of death*

• **Anita K. Bahn,** Philadelphia; Medical College of Pennsylvania, 1972; age 60, died July 18, 1980. Dr. Bahn was professor of research medicine at the University of Pennsylvania School of Medicine, deputy chairman of preventive medicine at Medical College of Pennsylvania, and senior epidemiologist of the Institute for Cancer Research at the Fox Chase Cancer Center.

• **Alex B. Cimochowski,** Forest City; Jefferson Medical College, 1930; age 78, died July 29, 1980. Dr. Cimochowski was on the staff at St. Joseph's, Carbondale, and Fairview State hospitals. He was a former mayor of Forest City.

• **Herman A. Gilda,** Chambersburg; University of Pennsylvania School of Medicine, 1925; age 79, died July 24, 1980. Dr. Gilda was a heart and lung specialist in Chambersburg for almost 40 years. He was an honorary life member of the Tuberculosis and Health Society of Central Pennsylvania.

• **M. Morton Gratz,** Pottstown; Hahnemann Medical College, 1939; age 68, died July 15, 1980. Dr. Gratz practiced medicine in Pottstown for 34 years and was a general surgeon on the staff at Pottstown Memorial Medical Center.

• **William Lloyd Hughes,** Johnstown; Jefferson Medical College, 1932; age 78, died August 16, 1980. Dr. Hughes served as a personal physician to the late Sir Winston Churchill. He had been on the surgical staff of Memorial Hospital and was medical director of the American Red Cross Johnstown Regional Blood Center.

• **Kunj Behari Kichlu,** Erie; Hahnemann Medical College, 1931; age 91, died July 18, 1980. Dr. Kichlu started his practice in medicine and minor surgery in Erie in 1932. He had served on the staff of Saint Vincent and Hamot hospitals.

• **William Frederick George Klueber,** Pittsburgh; Hahnemann Medical College, 1939; age 65, died July 23, 1980.

• **Francis Joseph E. Preis,** Croydon; Hahnemann Medical College, 1943; age 60, died August 13, 1980. Dr. Preis practiced medicine in Croydon for 32 years.

• **George Elbert Pugh,** Clark's Summit; George Washington University School of Medicine, 1938; age 69, died July 29, 1980. Dr. Pugh had been surgeon in chief and medical staff president at Moses Taylor Hospital for 15 years. He had been named the 1980 winner of Man of the Year Award of the St. David's Society of Lackawanna County.

• **Sidney Safran,** McMurray; University of Maryland School of Medicine, 1937; age 69, died August 17, 1980. Dr. Safran was a physician and surgeon in the Canonsburg area for 40 years.

• **Malcolm S. Stevenson,** Finleyville; University of Pennsylvania School of Medicine, 1933; age 73, died July 24, 1980. Dr. Stevenson was a retired staff member at Monongahela Memorial Hospital.

• **Kee Toh Tan,** Hatfield; Howard University College of Medicine, 1956; age 51, died August 9, 1980. Dr. Tan was the resident pathologist at North Penn Hospital in Lansdale.

• **John Sheffield Tennant,** Harrisburg; University of Virginia School of Medicine, 1947; age 58, died August 4, 1980. Dr. Tennant was an associate director of physical medicine and rehabilitation at Polyclinic Medical Center, Harrisburg.

**Leonard Berwick,** Wallingford; University of Pennsylvania School of Medicine, 1952; age 65, died July 19, 1980. Dr. Berwick was associate professor of pathology at the University of Pennsylvania School of Medicine. He also conducted research in cancer and diabetes and was the recipient of the Lindbach Award for Distinguished Teaching.

**James A. Thomas, Sr.,** Media; Jefferson Medical College, 1928; age 81, died July 13, 1980. Dr. Thomas was a family practitioner in Philadelphia for 40 years. He had served as a physician for the Philadelphia school district and had been a consultant for the Pennsylvania Department of Vocational Rehabilitation for 13 years.


**The Basic Science Section of the**
**College of Physicians of Philadelphia**
**offers a postgraudate seminar**

***The Kidney: Basic Science and Clinical Practice***

**Friday, November 21, 1980**

**to be presented by:**

**Michael W. Weiner, MD**
**Assistant Professor of Medicine**
**Stanford University School of Medicine**
**Palo Alto, California**

**Robert Narins, MD**
**Professor of Medicine**
**Temple University School of Medicine**
**Philadelphia, Pennsylvania**

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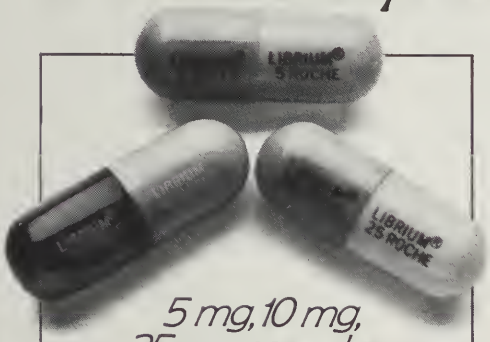


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- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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# Librium®
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5 mg, 10 mg, 25 mg capsules

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Please see preceding page for a summary of product information.

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Pennsylvania Medicine

Vol. 83, No. 11 NOVEMBER 1980

# PMS MEMBER OPINIONS

1980 SURVEY RESULTS REVEALED

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

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## Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

**Contraindications:** Hypersensitivity to the drug.
**Precautions:** *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
**Adverse Reactions:** Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
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# medigram

**ACT 111 ARBITRATION NOW ONLY VOLUNTARY**

Pennsylvania still has an arbitration system for medical malpractice cases, but it is voluntary rather than mandatory. The mandatory arbitration system was declared unconstitutional by the Pennsylvania Supreme Court September 21. The 5-2 court decision holds that the law "has failed in its goal to render expeditious resolution to malpractice claims and consequently imposes an oppressive burden upon the right to jury trial guaranteed by our state constitution." Attorney General Harvey Bartle, III ruled on October 14 that only the "original exclusive jurisdiction (of arbitration panels) to hear and decide" health care malpractice cases was voided by the Supreme Court decision. He said that arbitration continued "as a voluntary system" if all parties consent to this mechanism for resolving disputes. Arthur S. Frankston, Esq., administrator of Arbitration Panels for Health Care, said his office has notified all parties to arbitration cases now pending of the voluntary status and has given them until December 15 to transfer the cases to the appropriate courts. He said his office would retain jurisdiction over all cases whose principals do not respond by that date. In almost five years since the effective date of Act 111, nearly 4,000 cases have been filed, but only 51 arbitration panels actually heard cases. Of the 48 claims filed during the first year, 1976, five remain unresolved. Claims ended other than through arbitration number 1,025, but more than 2,600 cases remain unresolved from those filed up to July 31, 1980.

**CAT FUND COVERAGE NOW FOR ALL CASES**

Catastrophe Loss Fund coverage, limited by a ruling of the attorney general to those malpractice cases filed for arbitration, now includes all cases involving Pennsylvania insured health care providers covered by Act 111. PMS caused the introduction of H.B. 2204 because of concern for physicians against whom cases were filed in U.S. courts for geographic reasons.

**FURTHER AMENDMENTS ASSURE FUND'S LIFE**

Amendments to H.B. 2204 saving the Catastrophe Loss Fund from potential financial disaster are now part of Act 111. The amendments are intended to maintain the CAT Fund despite increasing payouts. The Fund provides million dollar insurance in the medical malpractice cases. Under Act 111 physicians now must carry $100,000/$300,000 insurance coverage, and settlements above that amount are paid by the CAT Fund. With the amendments in place, the physician's basic limits coverage will increase to $150,000/$450,000 if the Fund pays out more than $20 million in any one year, and to $200,000/$600,000 if the payout exceeds $30 million in any year after 1982. An amendment also eliminates the 10 percent ceiling on the surcharge a physician pays for the million dollar coverage. The first effect of this amendment may be an increase in the 1981 surcharge. Investigation shows, however, that CAT Fund coverage is cheaper than million dollar coverage from private insurors. Other amendments give primary insurors the right to agree before the CAT Fund can settle and require the Joint Underwriting Association to repay the CAT Fund any money paid out in the JUA's behalf.

LAETRILE SUPPORTERS SUFFER COURT DEFEAT

The U.S. Supreme Court on October 20 let stand a federal appeals court ruling that bars the acceptance of laetrile into general use as a cancer treatment. A federal appeals court had ruled that laetrile did not qualify for an exemption under the 1962 drug act amendments, which say drugs in general use as safe and effective prior to 1962 do not need to meet current FDA standards. The high court also left intact the appeals court ruling that the privacy rights of cancer patients to choose their treatments are not violated by the denial of laetrile. Although legislatures in 14 states have approved laetrile for cancer treatment, it is barred from interstate use or shipment. The National Cancer Institute launched a clinical test of the substance as a cancer treatment last July.

WELFARE DEPARTMENT MEMO TRIES TO SIMPLIFY MAMIS

The Department of Public Welfare has issued a six-point memo in an effort to end confusion over billings for Medical Assistance patients under the Medical Assistance Management Information System (MAMIS) which became effective September 1, 1980. The points are:

1. Submit all MA bills to: Department of Public Welfare, Office of Medical Assistance, P.O. Box 8297, Harrisburg, PA 17105.
2. Use Form MA 305--no other form will be accepted.
3. List only five services per form.
4. Use only the new Medical Assistance Identification Number sent by DPW. Do not use the Medicare ID number.
5. Follow the instructions in the Physician's Services Handbook.
6. For further information call 800-932-0698.

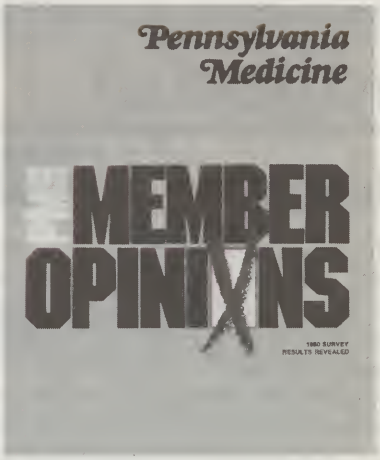
GOVERNOR APPOINTS THREE PHYSICIANS

Governor Dick Thornburgh recently appointed three physicians to openings on state panels. John L. Kelly, MD, of Springfield (Delaware County), was named to the Advisory Health Board of the Pennsylvania Department of Health. John H. Moyer, III, MD, of Johnstown, was appointed to the State Board of Medical Education and Licensure, replacing John W. Robertson, MD, of Philadelphia, whose term expired. John Karlavage, MD, of Mahanoy City, will serve on the Governor's Council on Drug and Alcohol Abuse.

PSYCHIATRISTS SEEK TO MEET GOVERNOR

Concern about a decline in the quality of state mental health programs has caused the Pennsylvania Psychiatric Society (PPS) to seek a meeting with Governor Thornburgh. Stanley P. Laucks, MD, PPS president, in asking for the meeting, cited a welfare department study which documents the decline in the quality of care at state mental hospitals. Dr. Laucks said the state's substandard pay scale prevents recruitment of physicians. Dr. Laucks said recent allegations of ill psychiatrists treating state hospital patients are "reckless" and "damage the credibility of all physicians in state service . . . the real problem . . . is that the quality of care at the state's 18 mental hospitals is slipping because of the lack of psychiatrists to treat patients." PPS also attacked regulations which allow community mental health programs to function with virtually no physician-patient relationship.

Pennsylvania Medicine

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PENNSYLVANIA MEDICINE
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

PUBLICATION COMMITTEE
Carol N. Maurer, MD, Chairman, Oil City
Ralph S. Blasiole, MD, Washington
John J. Danyo, MD, York
J. Mostyn Davis, MD, Shamokin
Robert S. Pressman, MD, Philadelphia

STAFF
David A. Smith, MD
Medical Editor
Mary L. Uehlein,
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CONTRIBUTING EDITORS
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# editorial

## Health: an individual issue and effort

In July of 1979, the Surgeon General's Report of Health Promotion and Disease Prevention, entitled *Healthy People,* was released by the U.S. Department of Health, Education, and Welfare. As he notes with pride in his forward, Joseph Califano released this book as his final act as Secretary of Health, Education, and Welfare. Mr. Califano had and has every reason to be proud. It is obvious that the book required a great deal of research into the past and thought for the future as outlined by the eminently achievable goals for bettering the nation's health.

Beginning with the delineation of the shift in disease patterns in this country from 1900 to 1970, the observation is made that at the turn of the century, following the control of infectious diseases like tuberculosis, small pox, and pneumonia, the more chronic but still preventable diseases have come to the fore. These include cancer, heart disease, and stroke. Major risk factors for these diseases, such as smoking, alcohol and drugs, and diet are discussed along with the possible preventive measures.

Reduction of infant mortality by reducing contributing factors, both inherited and environmental, is reviewed. A goal of 35 percent reduction by 1990, to less than 9 deaths per 1,000 live births, has been set.

"The report's central theme is that the health of this nation's citizens can be improved significantly through actions individuals can take themselves, and through actions decision-makers in both the public and private sectors can take to promote a safer and healthier environment for all Americans at home, at work, and at play."

The goals detailed in this book should be adopted by as many private sector volunteer health agencies, hospitals, and physicians as possible. Government needs to be involved in enforcing motor vehicle speed laws and ensuring adherence to certain occupational safety standards, but health is largely an individual issue and effort. An individual cannot be forced into good health.

Each person must be made aware of the consequences of his actions in regard to his own well being and that of others. Many nonsmokers feel that smokers are poisoning the air for everyone else. People living downstream are painfully aware of the pollutants dumped upstream by thoughtless companies or individuals. Good health is an educational challenge, not a government mandate.

Diet, hypertension, cancer, infant mortality, and many others merit note of existence as problems. The government's role should be in areas such as research support, perhaps in the form of grants. What can be accomplished by the private sector, by concerned citizens, should preclude any government intercession.

In certain areas, however, there is a decided need for a coordinated effort. For example, reducing infant mortality and perinatal death requires adequate prenatal care. It is unrealistic to expect providers to donate their time in the current socioeconomic climate.

Medicare and medicaid have accustomed providers to receiving payment for services that in 1900 would have been rendered free. The government probably will need to bear the costs of financing prenatal care because there are no other alternatives for the low- or no-income population and pregnant adolescents.

This excellent book is well worth reading. *Healthy People* is available from the U.S. Government Printing Office at $5.00 per copy.

Much has been accomplished by American medicine in the past 80 years; but much more remains to be done in reducing man's mortality. More importantly, the goals of preventive medicine should be improving the quality of life and preserving the dignity of that life. The goals set by *Healthy People,* if achieved, should be a major step toward fulfilling a longer and more productive life.

David A. Smith, MD
Medical Editor

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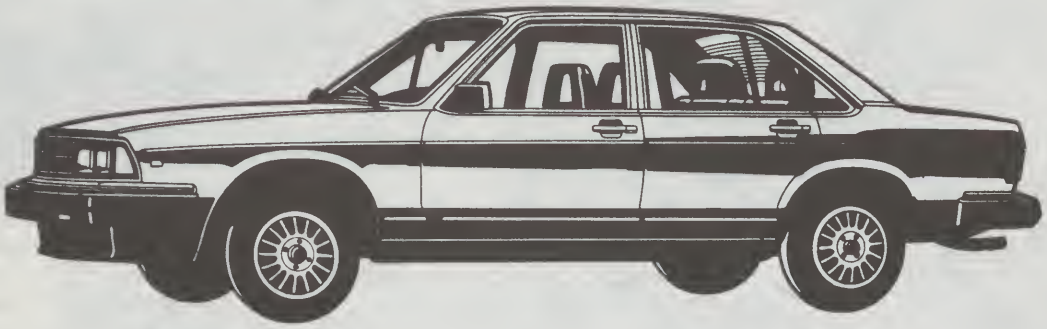

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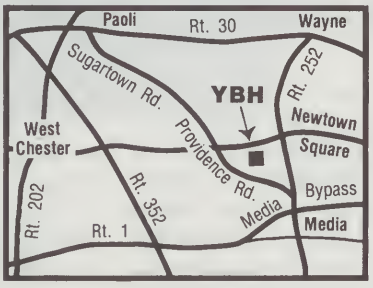


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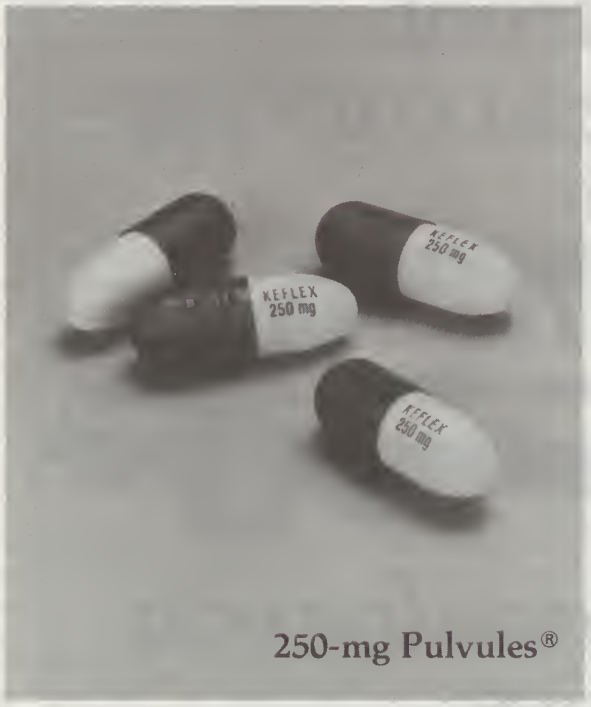

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# newsfronts

## Managing State Society's future is goal of planning

Planning for tomorrow—managing the future of the medical profession—these are the goals of the Society's Committee on Planning and Evaluation. Established by the Board of Trustees a year ago, the committee currently is studying the information gathered in a survey of all members conducted by Hay Associates of Philadelphia this summer, and discussed in an article on page 18 of this issue.

To learn how the findings of the survey will be used, PENNSYLVANIA MEDICINE interviewed Leroy A. Gehris, MD, now PMS president, as he completed a year as the committee's first chairman.

**Hasn't the Society been doing planning all along?**

Yes—planning is closely related to any activity we undertake, but is not easily separated from everyday activities. Each day we are planning—in our day to day decisions and in the budgeting process. But are we clear on long-term objectives? Does everyone understand and concur in the plan? It is the planning involving everyone which we are embarking on now.

**Would you call this consensus planning?**

If you mean getting everybody to agree that this is what we have to do, then the answer is yes. Successful planning cannot be imposed from on high. That's why we started with a poll of the members. Everyone must understand, because to be successful our activities must have wide participation. People don't participate in activities they don't understand. Additionally this planning process calls for an analysis of the outside environment including documentation of the findings before the Society takes a position. Medicine is in crisis and our tendency is to take immediate action. Through the process of establishing goals and objectives we should, in the long run, be able to anticipate crises and manage them. Planning involves the allocation of resources, so it naturally addresses the question of how to build the best possible organization to do the job.

**You mentioned a mission statement—what does that mean?**

The mission statement is an operating guideline for the Society. It answers the question, "why are we in business?" It isn't enough to come up with a "motherhood" statement. The mission statement should be broad enough to be unchanging over the years and yet specific enough to give us some real basis for operations. Developing a good mission statement isn't an easy assignment. Once we have one, the next step is to determine which are the best ways to achieve the mission. These become objectives, the major chunks of business that we need

to achieve in order to be successful. Then we need to place our objectives in order of priority, and break them down into "do-able" pieces. These become our programs, or goals. Involved here are actual work plans, time frames, measurements for success, and allocation of appropriate resources—time, money, and staff. As you can see, everything proceeds naturally from the mission statement. That's why it's so important that it be carefully designed. It all boils down to doing the right things first, using resources in a way to achieve the best results, and avoiding big surprises, if possible.

**How has PMS proceeded in the new planning process?**

The first step in planning is to determine where you are. Our first move was to check the membership's perception of their association. We contracted with Hay Associates to conduct a survey of the entire membership. That activity is now completed, and some of the results appear in this issue in an article by Linda McAleer. Thanks to the overwhelming response of our members, we now have accurate data to measure how well our current programs correlate to the concerns of the members. We know what kind of grades they're giving the Society's performance. Too many organizations go on without ever knowing these things, even though they are fundamental to planning.

**What activity followed the survey?**

On September 13 and 14, the Board of Trustees held a special meeting. Included were representatives of each major Society division. First we heard a detailed report from Hay personnel on the survey findings. Then task forces met to develop objectives designed to meet the needs of the organization as revealed by the survey.

**What is the next step?**

Now the Committee on Planning and Evaluation will complete a final version of the mission statement for the approval of the Board of Trustees. The committee also will study the objectives developed by the task forces, refine them, fill in the gaps, and put them in order of priority for Board approval.

**How will that affect the Society's day to day activities?**

Once the mission statement is in place and PMS objectives established, then both budgeting and programs must serve those objectives. Priorities will be established. Allocation of time, staff, and money will be made according to priority—the old idea of doing first things first. People will understand that some things must wait while others are being done. Councils and committees will be responsible for carrying out programs that meet the objectives, and we'll measure the results.

**Can you give our readers an example?**

Yes. In keeping with one part of our mission—to federate the medical profession in Pennsylvania, one of our objectives obviously is to increase membership so that we physicians remain strong and credible as one representative *vis a vis* government and others. There are conflicting data on the number of physicians practicing in Pennsylvania and who are our real candidates for membership. A survey of nonmembers is essential to discover this, and what it will take to recruit them. We need to study the environment in which recruiting takes place. Currently our recruiting is complicated by the 60 sets of rules used by county societies to screen proposed members. Careful, even tedious, processing was needed years ago, when diploma mill charlatons were passing themselves off as physicians on an innocent public. Thanks to the efforts of organized medicine, today we have uniform standards of education and licensure. Recruiting efforts, then, must take a different approach, possibly with aggressive marketing. After we find out who are recruitable, and what it will take to recruit them, we must design a marketing approach that will reach them and an operational approach that will change the present system of processing new members. All we really do today is process memberships. We don't actively recruit members or market organized medicine. That has to change if we're going to achieve this part of our mission.

**What is the timetable for implementation of the planning process?**

We will begin to see some progress in 1981. The programs and budgets developed in 1981 for 1982 should feel the full impact of planning. The nonmember survey is already scheduled, so in that respect, we could say we already have begun to implement the planning process.

**What do you, personally, see as the results of planning?**

I foresee a greatly strengthened medical profession of 60 county societies, over 300 hospital medical staffs, and 23 specialty societies in Pennsylvania working through the Pennsylvania Medical Society. I see us being much more effective in our dealings with government. I see an improvement in the public's perception of the medical society as a socially responsible organization, interested not only in the welfare of physicians, but also in the health and well-being of all citizens in the Commonwealth, including the poor, the aged, and children. I see the Society having much greater research capacity, so that we can measure the results of our efforts. We will, of course, share those results with the membership, so that everyone will have an idea of how well we're doing. I see government, both the regulatory agencies and the legislature, coming to PMS for information, because through planning we will have the needed data. And I see the Pennsylvania Medical Society playing a large role in the AMA as it strives to develop greater national leadership in health affairs.

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# State Society publishes patient education pamphlet

A pamphlet to assist patients in determining when to see their doctor is available from the Pennsylvania Medical Society.

The pamphlet, "When to call or see your physician," is part of the cost containment effort.

Matthew Marshall, Jr., MD, PMS president, said, "The physicians of Pennsylvania share the public's concern about rising prices. We are continually striving to provide quality medical care at reasonable costs.

"One of the ways the public can help contain medical costs is to use the services of doctors wisely. We hope that this pamphlet can help our patients hold down medical bills without shortchanging their health."

PMS members who wish to distribute the pamphlet to their patients should write for copies to: Pamphlet, PMS, 20 Erford Rd., Lemoyne, PA 17043.

## Federal funds support state's diabetes project

Pennsylvania has been selected as one of 20 states to participate in a national diabetes control project. U.S. Senator Richard Schweiker, (R., Pa.), and Governor Dick Thornburgh announced that 1980 is the first year Pennsylvania has received federal funds for the state-administered program.

The governor said the health department will receive a 15-month, $174,000 federal grant to develop its diabetes control program. The project will be a cooperative effort of the health department, the Center for Disease Control in Atlanta, and a diabetes task force appointed by the governor.

Senator Schweiker said Pennsylvania first will assess the incidence of diabetes and the scope of the associated problems and then develop a program to combat the illness.

**The 1980-81 Membership Roster is available from the PMS membership department. The roster contains: component county society officers; component county society members with addresses and specialty codes; and an alphabetical listing of PMS members showing county affiliation.**

**According to PMS policy, members may receive a complimentary copy of the roster upon request. Copies are available for nonmembers at $40.00 each.**

## PMS sponsors management workshops for residents

The Pennsylvania Medical Society is sponsoring a management program for residents in training programs in the state. The program, "Establishing a medical practice," is presented in a workshop format to help residents learn how to start their practices.

The workshops will be offered at three locations:

- Pittsburgh, December 9, 10, 1980 — Allegheny County Medical Society, 713 Ridge Avenue — Practice Productivity, Inc.
- Philadelphia, December 11, 12, 1980 — Philadelphia County Medical Society, 2100 Spring Garden Street — Practice Productivity, Inc.
- Harrisburg, April 7, 8, 1981 — Marriott Inn — Conomikes Associates.

The workshop costs $95 for PMS/AMA members or those planning to join, and $125 for nonmembers.

Registration is limited to 35 residents. Residency program directors have assisted residents by partly subsidizing their attendance at these seminars in the past.

For further information contact LeRoy C. Erickson, Director of Educational Activities, PMS, 20 Erford Rd., Lemoyne, PA 17043.

## Philadelphia celebrates hospital's 125th year

Children's Hospital of Philadelphia, which established the specialty of pediatrics, will observe its 125th anniversary on November 23, 1980.

Several Philadelphia institutions have agreed to participate in the celebration. They include the Philadelphia Orchestra, the Historical Society of Philadelphia, the Free Library of Philadelphia, the Philadelphia Zoological Society, and the College of Physicians of Philadelphia.

The college and the hospital will cooperate in a joint celebration at the November College Night. C. Everett Koop, MD, surgeon-in-chief at the hospital, will present a lecture on "The newest specialty for the smallest patient."

Other celebrations include an exhibit of historical memorabelia of the first 125 years of the hospital's role in Philadelphia medicine at the Mutter Museum, and the international scientific conference of pediatric nephrologists at the hospital.

## State awards funds to emergency councils

The state health department has awarded contracts totaling more than $1 million to eight regional emergency health service councils.

The contracts will provide funds for training programs, communication planning and development, public education and information programs, and efforts to improve basic and advanced level ambulance services.

William C. Dethlefs, director of the department's emergency health services division said, "A major effort this year will be to assess hospitals and their ability to deal with serious injuries, and to designate trauma centers."

The councils awarded contracts include: Eastern Pennsylvania Emergency Health Services Council, Allentown, $126,610; Emergency Federation of South Central Pennsylvania, Camp Hill, $201,290; Emergency Medical Services Institute, Pittsburgh, $422,048; Emergency Medical Services of Northeastern Pennsylvania, Avoca, $74,250; Emergency Medical Services Council of Northwestern Pennsylvania, $158,307; NY-PENN Health Systems Agency, Binghamton, New York, $76,508; SEDA-COG Emergency Medical Services Program, Lewisburg, $175,768; and Southern Alleghenies Emergency Health Services Council, Altoona $161,214.

# New planning regulations in effect

Hospitals and other health care facilities must provide additional evidence that a need exists before they can expand or change their services according to new regulations under the Health Care Facilities Act.

The new regulations, effective July 30, 1980, bring this certificate of need law into compliance with federal requirements of the Public Health Service Act.

Thomas J. Travers, director of the state health department's division of need review explained, "Under previous health planning legislation, the penalties for expansion, changes in services, or purchase of costly equipment without a demonstrated need resulted in the loss of federal funds through medicare and medicaid."

"The current law," Travers said, "requires that plans be reviewed by the regional Health Systems Agency and approved by the health department. The law also requires the state to take legal action to halt unapproved actions. Facilities that proceed with unapproved actions risk losing their operating licenses."

According to the new regulations, a facility which operates without approval in the form of a certificate of need can be fined up to $1,000 plus costs of prosecution for each day it continues to operate after being notified to halt action.

The new regulations require local and state approval of the following changes:

- Construction, development, or other establishment of a health care facility.
- Capital expenditures in excess of $150,000 by a facility.
- Increasing the number of beds, or relocating beds, if more than ten beds are involved.
- Changing bed usage.
- Offering a service which before had not been offered regularly.

Further details concerning the new regulations can be obtained from the state health department.

## PMS insurance company names general counsel

The Pennsylvania Medical Society Liability Insurance Company has named Sarah H. Lawhorne, Esq. as its general counsel effective November 1, 1980.

She had been assistant attorney general for the Commonwealth and general counsel to the Medical Professional Liability Catastrophe Loss Fund.

Linda Lichtman, Esq., who preceded her, will continue as a PMSLIC consultant through November.

**John W. Burnside, MD, professor of medicine and chief of internal medicine at the Pennsylvania State University College of Medicine, Hershey, was incorrectly identified in the October issue as chairman of the department of medicine. Graham H. Jeffries, MD, has been and continues to be professor and chairman of the department of medicine at Hershey.**

## Day to quit smoking scheduled November 20

November 20, 1980 is the day the American Cancer Society has scheduled as the Great American Smokeout. The smokeout is a campaign to get smokers to quit for a single day with the hope that they will quit for good.

Nine out of ten smokers have tried to quit smoking or would try if they could find an easy way to do it, according to a recent report, "Adult use of tobacco in the USA" released by the National Clearinghouse for Smoking and Health. Most smokers, however, continue to smoke even though at least seven out of ten are worried about how it affects their health.

American Cancer Society officials are asking physicians to encourage their patients to quit smoking for the Great American Smokeout.

A recent Gallup survey revealed that 71 percent of patients who smoke would quit smoking cigarettes if their physicians urged them to do so. The survey also showed that more younger than older smokers would accept their physicians' advice.

The society estimates that it would take physicians 30 seconds to get 10 percent of their patients who smoke to quit.

Last year, close to 18 million smokers out of the 52 million in the US participated in the smokeout.


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# State JUA insures more podiatrists, fewer physicians

The Pennsylvania Professional Liability Joint Underwriting Association (JUA) insured almost as many podiatrists as MDs as of June 30, 1980.

JUA coverage of MDs dropped from 916 in June 1979 to 739 in June 1980. During that period, coverage of podiatrists increased from 688 to 730. JUA coverage of DOs dropped from 878 to 581 as osteopaths found other sources for professional liability insurance.

The association, which insured a total of 2,526 health professionals and facilities in June 1979, insured only 2,081 in June 1980. Written premiums for this period dropped from $2,901,802 to $2,065,262.

Established under Act 111, the health care services malpractice law, the JUA was mandated by the state to fill the need for professional liability insurance for those health professionals and facilities unable to obtain coverage in the private sector. Currently it provides the only coverage available to podiatrists, who are required to have malpractice insurance by Act III.

As of June 30, 1980, the JUA reported a total of 487 claims filed against its insureds. Of these, 337 are still open while 150 have been settled or dropped.

William H. Lehnert is general manager of the Joint Underwriting Association. It is governed by a Board of Directors composed of representatives of insurance companies writing casualty coverage in the state, the professional associations involved, and the general public.

## New law reduces hospital inspections

The new health care facility licenses law (PL 130, No. 48) allows the state health department to use survey findings from other accrediting agencies. The law is effective as of November 10, 1980.

Most hospitals submit to two inspections, one by the Joint Commission on Accreditation of Hospitals or some other agency for accreditation, and the one mandated by the Commonwealth's health department for operating licenses. The new law eliminates the need for the state health department to conduct its own separate inspection for licensure.

The health department still can inspect facilities that are not covered by other agencies or which seem to require a closer look.

## Blue Shield begins children's program

Pennsylvania Blue Shield has initiated a new program which, for the first time, incorporates preventive health care into a benefits package specifically designed for children.

The new benefit, Pediatric-Preventive Health Maintenance Program (P-PHMP), offers a basic package of child health care services. It emphasizes disease prevention and early detection.

Children age one month to eighteen years who are eligible under their parents' coverage will receive a prescribed series of procedures, including routine histories and physicals, diagnostic tests, and immunizations.

The program uses a specially designed Doctor's Service Report (claim form) which must be obtained by the subscriber prior to scheduling a doctor's appointment. The program also encourages parents to use their regular pediatrician or family doctor.

PBS developed the program in response to approaches from the Pennsylvania Public Employee Health and Welfare Fund. The goal of the Pediatric-Preventive Health Maintenance Program is to help children to obtain the proper immunizations and other pediatric services they might not otherwise receive.

## County health profiles available from state

The state health department's Health Data Center has produced health profiles for Pennsylvania counties and the Commonwealth.

The county profiles provide county specific data including population, leading causes of death, incidence of contagious diseases, and number and type of health care facilities.

Copies of the profiles and two other publications, "Vital Statistics for Pennsylvania 1906-1977," and "Vital Statistics for Pennsylvania Counties 1978," are available by writing to the Division of Health Statistics, Room 126, Health and Welfare Building, Harrisburg, PA 17120.

## Annual exhibit for physician artists

An annual national art exhibit strictly for physicians who are artists will be held from November 16-19, 1980 in San Antonio, Texas.

The American Physician's Art Association, in its 43rd year, invites all physicians who work in the fields of painting, sculpture, photography, graphic arts, design, and creative crafts to join the APAA to submit entries for the November exhibit.

Qualified judges will award prizes in the following categories: oil and acrylics (classical and modern), water color, sculpture, arts and crafts, photography, and graphics.

Membership is open to all physicians. For more information write to Milton S. Good, MD, Treasurer, APAA, 610 Highlawn Avenue, Elizabethtown, PA 17022.

### (717) 737-5349

The Pennsylvania Department of Health has announced a new emergency number to be used after business hours and on holidays and weekends.

The number (717) 737-5349 is that of an answering service which has names and home telephone numbers of key health department personnel who may be contacted in the event of urgent public health problems.

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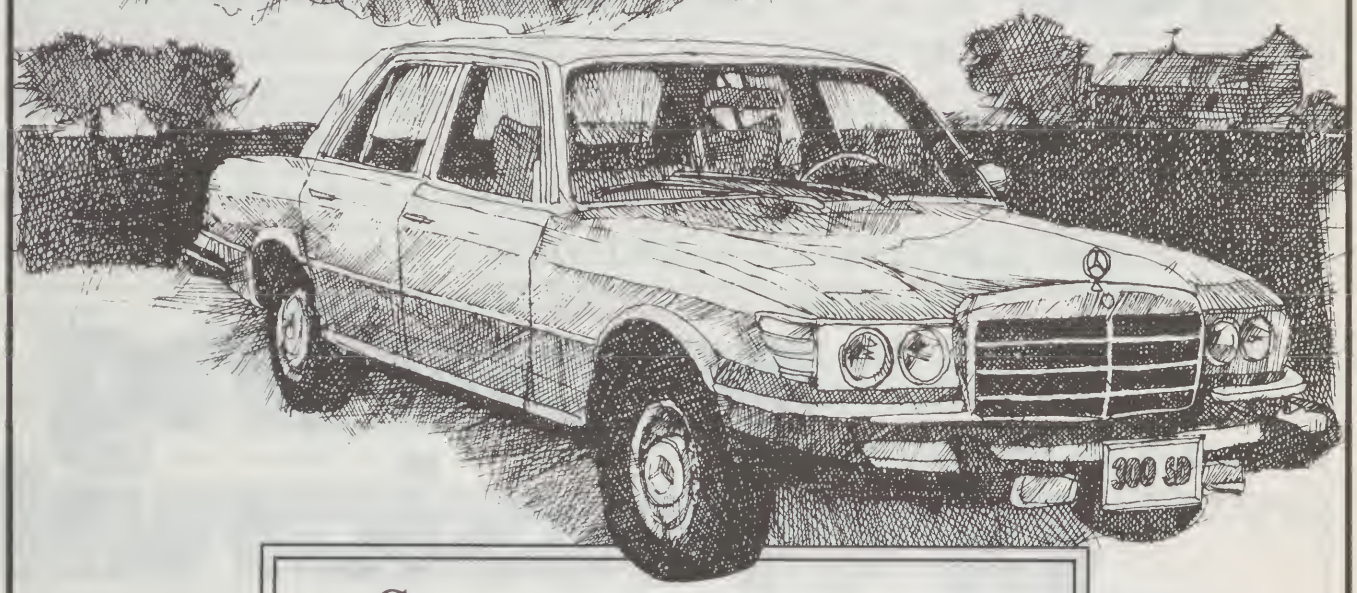


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## Legal counsel reports

# Peer review, foundation restraints serve public

**Fred Speaker, Esq.**

A federal Court of Appeals recently has issued an opinion[1] which should give some comfort to physicians.

The case involved a challenge on antitrust grounds made by the state of Arizona against two foundations for medical care, and a county medical society. The basis for the charge was the claim that maximum fees were set restricting what physician members could charge as full payment for the health services they provided to policyholders of insurance plans approved by the foundation for medical care. Arizona sought a summary judgment on the issue of liability which was denied by the District Court, and that denial was affirmed by the Court of Appeals.

Stating that the foundations for medical care "exemplify a type of organization that is beginning to play a significant part in the health services market," the court reviewed the activities of such organizations. They include polling their members to set upper limits on the fees they may charge which, it is claimed, supports the general purpose of establishing minimum standards and performing peer review. Participation in the foundations is open to all physicians.

Arizona charged that the fee schedules have raised physician fees so that from 85 to 95 percent of the physicians charge at, or above, the maximum fees set. Arizona contended that foundation membership agreements are contracts for fixed prices and added a separate charge that the foundations serve another anticompetitive objective by aiding in the exchange of price information.

The Court started its analysis of the case by considering a recent decision of the United States Supreme Court.[2] The Court said:

> The fact that a restraint may for one or more reasons appear reasonable is not controlling. An unreasonable restraint that contravenes the Sherman Act may be "based either (1) on the nature and character of the contracts, or (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices.[3]

The Court then considered the importance of whether a case is to be considered as a "per se" violation or whether the Rule of Reason is to be applied.

> The key, to repeat, is the agreement's impact on competition. If competition is promoted the agreement passes muster; if it suppresses or destroys competition it does not. Some agreements so often lack redeeming virtue, so frequently suppress or destroy competition, as to warrant their classification as per se unreasonable. *Broadcast Music, Inc. v. Columbia Broadcasting Co.,* 441 U.S. 1, 99 S.Ct. 1551, 1554, 60 L.Ed.2d 1 (1979). Once so classified a violation of the Sherman Act is made out merely by proving that such an unworthy agreement exists. Actual proof of its competitive impact is unnecessary. It is presumed to be anticompetitive. The State of Arizona insists that the practice of setting maximum fees by majority vote of the members of the FMC constitutes an arrangement without redeeming virtue that suppresses and destroys competition and is thus unreasonable per se. The difficulty with Arizona's position is that this record reveals nothing about the actual competitive effects of the challenged arrangement nor do the authorities, primary or secondary, afford assurance concern-

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*


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ing its competitive impact. In truth, we know very little about the impact of this and many other arrangements within the health care industry. This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement.

There are, however, additional reasons. Foremost among them is that we are uncertain about the competitive order that should exist within the health care industry pursuant to the Sherman Act as interpreted by the courts.[4]

The Court, recognizing that professions had been specifically brought under the control of the Sherman Antitrust Act in 1975,[5] said that the health care industry presented a particularly difficult problem. It must be understood, the Court wrote, that access to the medical profession is expensive and various governmental programs have artificially inflated that expense. Thus, the Court reasoned, a determination must be made about whether the challenged practice increases the prices charged for medical services. The Court concluded that the record did not show this.

Arizona argued that the Supreme Court has determined that any collective effort which tampers with price structures offends antitrust policy.[6] The Court responded to this argument, saying, "the issue whether to so classify the price schedules in this case is by no means 'a simple matter'."[7]

The majority opinion concluded with the following observation:

> We conclude by observing that we draw comfort from the Supreme Court's reiteration in *National Society of Professional Engineers,* 435 U.S. at 696, n.22, 98 S.Ct. at 1367, n.22, of its statement in *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 572 (1975) that marketing restraints that regulate professional competition may pass muster under the Rule of Reason even though similar restraints on ordinary business competition would not. We believe this recognizes that a restraint may serve the public, the transcendent end of all professions, even though its presence in a purely commercial setting would violate the antitrust law. See *Professional Engineers, supra,* 435 U.S. at 696 & n.22, 98 S.Ct. at 1367 & n.22; *Boddicker v. Arizona State Dental Ass'n,* 549 F.2d 626 (9th Cir. 1977). There is sufficient probability of the challenged practice in this case being sheltered by this principle to justify our refusal to brand it as a per se violation.[8]

Thus a high federal court gives some support to physicians who want to argue that their practices in peer review and foundations for medical care are reasonable, are not anticompetitive in design, and are intended for the good of society.

---

1./ *Arizona v. Maricopa County Medical Society, et al.,* 1980-1 Trade Cas. (CCH) §62, 239 (9th Cir. 1980).
2./ *National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978).
3./ *Arizona v. Maricopa County Medical Society, supra.*
4./ *Ibid.*
5./ *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975).
6./ Citing *United States v. Socony-Vacuum Oil Co.,* 310 U.S. 150 (1940).
7./ *Arizona v. Maricopa County Medical Society, supra.*
8./ *Ibid.*


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The reservation deadline is January 15, 1981. For further information call (800) 558-7990 (Wisconsin residents call (414) 327-6030) or write Dr. Jagmeet S. Soin, MD, Division of Nuclear Medicine, 8700 W. Wisconsin Avenue, Milwaukee, WI 53226, (414) 257-5968.

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# PMS MEMBER OPINIONS

# Members' response to survey enhances future planning

**Linda J. McAleer**

Nothing aids sound planning for the future more than accurate information about present circumstances.

With that in mind the Pennsylvania Medical Society contracted with Hay Associates of Philadelphia to survey the entire membership. The response rate of more than 50 percent lends substantial weight to the findings and significantly enhances the survey's usefulness in future planning.

To many members, their professional association represents a sense of stability for the future of a career many years in the making. The role that an association plays does much to establish and re-establish the image of a particular profession. That image, once developed, sets the standard for new practitioners as well as outsiders viewing the profession to follow.

In preparation for future growth and development of the association as a professional connection between the physicians and the many types of publics with which they interface, the Pennsylvania Medical Society agreed to look at its current status with the group it serves—the member physician population in the state of Pennsylvania. PMS's hope was that its membership would help it frame those issues most important to the practice of medicine and those benefits that members want from their professional association.

Hay Associates, through two of its divisions, Research for Management and Strategic Management Consulting, provided the tools for PMS to evaluate its present status and its future directions. Assistance came in two ways: formulating the structure for a long-range plan for PMS and surveying the interests and opinions of members toward their association.

This article's purpose is to communicate to members the results of the survey. Since members take the time to contribute, it is important to feed back the product of their collective efforts—analyzed to give PMS the data needed for the strategic planning process.

## Survey objectives

There were four primary reasons for conducting the "all member opinion survey:"

1. to identify the pertinent issues and needs facing members;
2. to look at PMS through the eyes of its membership;
3. to aid the long-range planning and decision-making processes; and
4. to establish "benchmarks" for tracking members' opinions over time—to know the impact of certain PMS actions and programs.

## Survey process

All of the approximately 14,400 PMS member physicians were sent a four-page questionnaire in June, 1980 by Research for Management. It was encouraging to receive more than a 50 percent response—a higher response than in many surveys. It showed that members have a commonality of interest in the image of medicine and a professional concern for the future of medicine through the 1980s. From the questionnaires returned, we were able to learn much about the profile of members and what they find important in PMS. We were then in a position to offer some suggestions as to what the membership might expect from their professional association.

## Membership profile

Almost all members practice medicine full-time (80 percent), with 47 percent in solo practice. The younger physicians tend more toward group practice; the older ones practice medicine alone. Ninety-five percent of members are males, with many of the females under 30 years of age and often in residency. A third of the members are either in general practice or internal medicine.

Geographically, 32 percent practice primarily in Allegheny and Philadelphia counties and 48 percent describe themselves as having city or metropolitan area practices. Thirty-nine percent have been physicians for more than 30 years and another 39 percent for less than 20 years.

The leadership of PMS and those who feel they are very involved in their association are typically older; the younger physicians are more involved at the county level or with their specialty societies, hopefully prior to becoming more active at the state level.

## Issues

From the perspective of members of all types, the consensus is that the general public views physicians with *less* respect now than five years ago. Only 2 percent felt that the image had been enhanced. In that regard, members overwhelmingly want to see PMS address the issue of the public image of the physician (75 percent want PMS to place more emphasis here).

*The author is director of marketing research for Hay Associates in Philadelphia.*

The issues of most importance for PMS to address related to governmental and public pressures:

- public image of medical profession (75% "more emphasis")
- impact of state government involvement in health care (58%)
- ramifications of National Health Insurance (56%)
- physician/patient relationship (55%)
- relationship with third party payers (55%)

Liability and malpractice issues are much more important to young physicians, who ranked them in their top five concerns. Older physicians named cost and availability of quality medical care as their concerns.

Overall, there is a positive feeling about the way the Society responds to the most important concerns of its members. Almost 75 percent of the members found their professional association very or somewhat effective. Seventy-nine percent said they would recommend membership very or somewhat enthusiastically to new resident physicians. The loyalty of members seems to grow as years in practice increase.

Members have definite views of their association. They look at it as traditional (58 percent), competent (50 percent), conservative (45 percent), and practical (38 percent). The more involved a member is, the higher the view of competency (78 percent) and effectiveness (58 percent).

**Services and benefits**

The Society's most important services to its members are in the area of legislative activities. Fifty-three percent felt more emphasis should be placed on legislative affairs and lobbying efforts. The same percentage felt the Society should devote more time to its relationship with the state government.

Members expressed much concern about the need for self-monitoring of the profession. Forty-two percent wanted more emphasis placed on impaired physician counseling, discipline of physicians, and risk management.

It is interesting to note that although members want greater efforts placed in legislative and government activities, 34 percent wanted to see less in contributions to political candidates. It is as if a less materialistic approach should be extended to make the relationship between medicine and regulation more solid.

The overall availability of benefits is not a significant reason for joining the Society; however, for more than half the members (58 percent), professional liability insurance is a significant benefit of belonging.

Those physicians in group practice and those recently out of residencies are interested in learning more about how to manage their practices through PMS-sponsored seminars. Younger physicians seem to have more practical reasons for membership than do their older counterparts. The younger ones are looking for assistance in establishing themselves in their new profession; they want to use the available resources to provide them with pragmatic tools for setting up a lifelong career.

Motivations change with age. As the physician matures, the reasons for belonging to the professional association are less specific in terms of member benefits. They tend to focus on more monitoring and enhancing the practice of medicine.

Physicians belong to PMS for two basic reasons: to be representated in the state legislature and regulatory bodies (70 percent) and to have their interests and accomplishments communicated to the general public (60 percent). The perceived problem in dealing with the government and weeding through the maze of regulatory agencies, as well as the overwhelming feeling of the loss of respect for physicians by the general public, have created a climate where the professional association has been asked to play a precise role, to make it easier for the physician to practice medicine in Pennsylvania.

**Themes**

Several significant themes emerged from the research. Each of them should be considered as the Society plans its long-range objectives:

- Physicians do not always join PMS immediately after completing their residencies; the need for that professional connection may come after establishing themselves within the physician community.
- The appeals of Society membership vary by age and by type of practice; each group requires something a bit different.
- Physicians are greatly concerned about their public image; they perceive that the public image is suffering, and the majority of members want the Society to spearhead the effort to improve it.
- The more involved a member is, the more positive is the image of the Society, and the more the Society satisfies that member's needs; ideally, PMS would want to involve more members as a basis for attracting new members.
- No specific member benefit is central to joining PMS; however, a significant motivator to selected groups may be the availability of professional liability insurance.
- The appeal of PMS is more positive to older physicians; sustaining the Society's current growth depends upon attracting younger physicians. This means offering services and emphasizing issues of importance to the younger ones, while continuing to satisfy the older ones.
- The members of the Pennsylvania Medical Society see interaction with government, both the legislature and regulatory agencies, as the key issue. "Get the government off our backs," the members seem to be saying, "while we get on with the practice of medicine."

**Conclusion**

The most important element in developing a profession for the future is the membership of the profession today. Knowing what the current membership thinks, the Pennsylvania Medical Society can plan with greater precision to serve the members of the future.

For that reason the overwhelming response of members to the survey added immeasurably to its value as a planning tool. Many members sent personal comments about the Society, its officers, and the administrative staff along with the completed survey. All of these were reviewed by Hay Associates and the PMS Board. They provided valuable additional insight about the needs and interests of members, and will add to the strategic planning process for the future.

# Pennsylvania's AMA Delegation works hard at meetings

Whether it's July in Chicago or December in San Francisco, when the AMA House of Delegates meets, the Pennsylvania Family can be found in the thick of the action.

The Pennsylvania Delegation numbers 22, but this is an extended family! Added to that number are Pennsylvania's delegates to the AMA Auxiliary, spouses of delegation members and often some children, PMS members who serve as specialty delegates or in other official capacities for the AMA, and PMS and county society staff.

Under the leadership of John B. Lovette, MD, delegation chairman, and Raymond C. Grandon, MD, vice chairman, the Pennsylvanians caucused for a full day before the opening session of the AMA House at the annual meeting in Chicago last July, and each morning of the meeting at 7 a.m.

Every delegate had a reference committee responsibility and reported to the caucus as reference committee reports were considered.

Shown on this page and the next are Pennsylvanians in action at the July 1980 Annual Meeting of the AMA House of Delegates.

**Drs. John B. Lovette, and Raymond C. Grandon, chairman and vice chairman of the delegation, confer in the top photograph. Below, delegates study their handbooks during the Saturday caucus.**

**Kathleen Fletcher of New Castle was honored at the AMA Annual Meeting for outstanding achievement as a member of a Medical Explorer Scout Post 886 at Jameson Memorial Hospital. She is a premedical student at California Technological Institute this fall.**

**Jonathan E. Rhoads, MD, of Philadelphia, left, received the AMA's Thomas and Rodman Sheen Award at the 1980 Annual Meeting. The stipend of $15,000 was presented by John T. Reed, of Guarantee National Bank of Atlantic City. Hoyt Gardner, MD, then AMA president, is shown in the background.**

R. William Alexander, MD, reports to the Pennsylvania caucus on a reference committee hearing. Irving Williams, MD, and Betty Cottle listen.

Donald E. Parlee, MD, explains a reference committee report while David J. Keck, MD, who is chairman of the PMS Board, studies the text.

The Pennsylvania Delegation always is represented fully on the floor of the house. Shown above is a portion of the Pennsylvania Delegation's section at the 1980 meeting.

William Y. Rial, MD, of Swarthmore, is a Pennsylvania delegate, speaker of the AMA House of Delegates, and a candidate for AMA president elect at the 1981 Annual Meeting.

Michael P. Levis, MD, of Pittsburgh, is a Pennsylvania delegate and the chairman of the American Medical Political Action Committee.

## Pennsylvania Delegation to the AMA

### Delegates

R. William Alexander, MD
James B. Donaldson, MD
Henry H. Fetterman, MD
Raymond C. Grandon, MD
William J. Kelly, MD
Michael P. Levis, MD
John B. Lovette, MD
Matthew Marshall, Jr., MD
Robert N. Moyers, MD
William Y. Rial, MD
R. Robert Tyson, MD

### Alternates

Donald C. Brown, MD
Robert J. Carroll, MD
Betty L. Cottle, MD
Joseph N. Demko, MD
George R. Fisher, MD
Charles A. Heisterkamp, III, MD
Wayne W. Helmick, MD
David J. Keck, MD
John L. Kelly, MD
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The Pennsylvania Medical Society Auxiliary (PMSA), fourth largest state medical society auxiliary in the AMA Auxiliary, takes a place at the top in providing leadership. At the 1980 AMAA Convention, PMSA had 21 delegates—16 elected, one presidential, and four national delegates.

Mrs. Manuel A. Bergnes, immediate past president of the AMA Auxiliary, was chairman of the 1980 Nominating Committee. Mrs. Frank R. Kinsey, PMSA president, is a member of the 1980-81 AMAA Long Range Planning Committee.

Pennsylvania has provided a total of seven AMAA presidents—more than any other state. The PMS Auxiliary has had six of its members named honorary members of the AMA Auxiliary, again more than any other state.

The programs and activities of the PMSA and the AMAA promote the physical and mental wellbeing of Americans and people worldwide. Auxiliary activities in 1980-81 center around physical fitness as a means to good health.

Some delegates from PMSA to the 1980 annual convention of the AMA Auxiliary are shown here.

Mmes. Hirman E. Armstrong, Herbert B. Jordan, Jr., Victor F. Greco.

Mmes. John P. Whiteley, Earle R. Davis, Patrick H. Hughes, Luther H. Cone, Spencer J. Servoss.

Mmes. Howard F. Conn, Roldan G. Medina, Florencio Cardenas, Robert L. Harding, John H. Eves.

Mmes. Frans J. Vossenberg, Manuel A. Bergnes, John S. Parker

Mmes. Raymond C. Grandon and Robert Wasko.

Mmes. Michael J. Turock and Frank R. Kinsey with Auxiliary Executive Administrator Arlene C. Oyler.

Mmes. Raymond C. Grandon and Leroy A. Gehris.


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Continuing medical education

# Case studies with latent image printed text

Albert J. Finestone, MD

Continuing medical education should be self directed, adult education with readiness to learn developing from professional tasks and problems. Unfortunately much of the vast array of yearly offerings to physicians are not in this mold. In addition to those not related to practice problems, some programs are becoming increasingly expensive and require time away from practice.

The simulated Patient Management Problem (PMP) was developed as a result of growing dissatisfaction with more traditional methods of testing the knowledge and judgment of physicians. PMPs were designed to be a more accurate measure of clinical judgment than the usual type of questions. They require sequential decision making based on feedback from the answer sheet. The PMPs are increasingly popular in testing programs of medical schools, licensing, and certifying bodies.

The specific correlation of the PMP as a measure of clinical competence is difficult to prove, but it is now in wide use as a testing measure.[1, 2]

Recently this office adopted a modified simulated patient management problem as a continuing medical education instructional tool and not primarily as a testing instrument.

The technique allows us to offer this program as a nonthreatening, self assessment test with immediate feedback somewhat like a computerized clinical simulation, but without the expense. In cooperation with Medical Age Publishing Company, division of Wilcom Ltd., Stamford, Connecticut, we developed a series of home study CME programs using the principles of simulation in combination with a latent image printed text which reveals the outcome of every decision, when rubbed with a special pen.

Each program consists of an integrated series of individual, pocket sized, case study booklets. The design uses several proven educational techniques modified and adapted to the specific requirements of audience and subject matter. The case study method is familiar to every physician.

The clinical simulations designed by Temple University are structured to provide a sequence of "decision points" at which the physician must assess the available data and choose the appropriate next steps in managing his "patient."

For example, if the educational objective is to review the diagnosis and management of carcinoma of the lung, a case history of a patient with this problem is presented as follows:

A 46-year-old factory worker comes to your office complaining of an increasingly frequent cough, a ten pound weight loss in the past month, and anorexia. He has no other symptoms. He admits to having smoked a pack of cigarettes daily for the past 25 years but tells you he stopped a month ago.

Family history and past medical history are noncontributory. Review of systems reveals that he has developed headaches during the past three months; their frequency and severity have not increased, and the pain is relieved by aspirin. Physical examination, including a complete funduscopic and neurologic evaluation, is normal.

*Decision point 1* You proceed with the following work-up (Select more than one answer):
(a) chest x-rays, both posterioanterior (PA) and lateral
(b) complete blood count (CBC) with differential and platelet count
(c) collection of three sputum specimens for cytology
(d) full chest tomograms
(e) intermediate-strength PPD; sputum stains for acid-fast bacilli and culture for mycobacteria.

*Decision point 2.* You review the chest x-ray with the radiologist and concur that the most likely diagnoses are (Select more than one answer):
(a) small cell carcinoma of the lung
(b) squamous cell carcinoma of the lung
(c) adenocarcinoma of the lung
(d) bronchial adenoma.

This case then proceeds to a total of 13 decision points, each with multiple options and with appropriate x-rays, biopsies, and laboratory findings illustrated in the booklet.

Under each option, information is printed in invisible ink which is developed by the participant so that instant feedback can be obtained. Thenceforth, on making the decision, the physician develops the latent image by rubbing the area under each listed option with a specially designed felt-tipped marker which is supplied with the booklet. The information printed in invisible ink includes reasons why the option is or is not recommended.

## Immediate feedback

The importance of immediate feedback in education was emphasized by Skinner[3]. Murray, et al found that medical students who were given immediate feedback in a problem solving exercise increased their knowledge and ability to make patient management decisions.[4]

There are other methods of providing immediate feedback, but using invisible ink to produce a latent image has some advantages. These advantages include:

- Answers are given directly under the questions so that the reader need not turn to another section.
- When the answers are printed on

*Dr. Finestone is associate dean of continuing medical education and clinical professor of medicine at Temple University School of Medicine.*

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the same page, the participant may be tempted to read them before answering the question.

- Allowing a full discussion of the problem rather than just a simple answer as when an answer sheet is used.
- The completed booklet provides a permanent record of the case decision points and answers.

There has been a recent report in the British literature using this technique in problem solving and self assessment exercises.[5]

### Developing the programs

The development of each *Clinical Simulation* program begins with the assignment of a prominent clinician to serve as supervisor and editor for the series. The editor, in turn, engages an individual guest editor for each of the case presentations planned.

Subjects are chosen on the basis of medical importance, instructional value, and inherent interest. Patient histories and descriptions are given in sufficient detail to allow the physician to visualize the clinical situation including elements which ultimately may prove extraneous or even misleading.

At the end of each booklet, the guest editor provides a commentary on the salient features of the case and on the medical principles, problems, and pitfalls involved in clinical management. Although this section is essentially a supplement to the simulated case presentation, it is particularly useful in underscoring areas where clinical judgment and significant advances in medical knowledge or technology may influence the decision required in actual practice. Appropriate references also are listed.

For CME credit, the booklet may be returned to this office where it is reviewed and validated. Programs always are returned to the sender for future reference.

### Conclusion

To date *Clinical Simulations* have been produced in the following fields: surgery, pediatrics, dermatology, and cancer.

The response from practicing physicians almost uniformly, has been favorable with emphasis on enjoying the learning experience and appreciating the attempt to simulate "real" medicine.

Plans now are being made to objectively evaluate the effectiveness of this CME technique in comparison with more traditional methods. This report does not represent this approach as a dramatic new breakthrough, but as an innovation in answering some of the complaints of expense, time away from practice, and relevance that have been heard about more traditional CME offerings.

### REFERENCES

1. **Foran, M.J., Williamson, J.W., Gonnella, J.S.:** The validity of patient management problems. *Journal of Medical Education 48:*171-177, 1973.
2. **Page, G.G., Fielding, D.W.:** Performance of PMPs and performance in clinical practice: are they related? *Proceedings of the 17th Annual Conference on Research in Medical Education.* October, 1978.
3. **Skinner, B.F.:** The science of learning and the act of teaching. *Harvard Ed Rev 24:*86-97, 1954.
4. **Murray, T.S., Cupples, R.W., Barber, J.H., Hannay, D.R., Scott, D.B.:** Computer assisted learning in undergraduate medical teaching. *Lancet i:*474-478, 1976.
5. **Rogers, J., Harden, R.M., Murray, T.S., Dunn, W.R.:** The use of latent image printing in problem solving and self assessment exercises. *Journal of Audiovisual Media in Medicine 2:*27-29, 1979.

# Consultants bring expertise to recruiting process

Leif C. Beck, LL.B., CPBC
Vasilios J. Kalogredis, JD, CPBC
Geoffrey T. Anders, JD, CPA
Dorothy R. Sweeney

No matter how well you know the applicant, doctor, you should not shortcut the hiring routine. In an article in the October issue, we emphasized the importance of carefully recruiting and hiring medical office help. Creating a large pool of applicants, two interviews, skill testing, and reference checking were named as absolute necessities.

Yet, what about the individual doctor or group looking for an administrator or office manager? Who gets involved in the hiring routine for that person? Staff really cannot interview for their own supervisors, nor do they normally have the experience and talent needed. The physician does not have the time to devote to the preliminary (but important) work of culling down applicants to the best two or three for a final comparison interview.

The medical management consultant, working closely with the doctor or group can be a good intermediary in the recruiting and hiring process, especially when looking for an office manager or administrator.

More medical practices, even those previously considered too small for an office manager, now are finding a lay person trained in the business aspects of running an office to be a good investment. But physicians often tell us they have no idea how to go about finding such a person. Thus, even with the obvious need for a lay administrator, the position is not filled for lack of someone to take charge of the beginning process. Or, one staff person is promoted upwards by default without thought to the administrative needs of the job, often with disastrous results.

Medical management consultants can bring a unique brand of expertise to the recruiting process. The knowledge of so many other medical practices on which to draw comparisons, combined with day to day business experience permits them to grasp the desired job and determine the qualities and experiences needed to fill it.

Appropriate skill tests can be individually designed to meet the needs of the job. A bookkeeping test could be designed if the job involves that skill. Role playing questions designed to test an applicant's "people skills" could be administered.

While consultants are not normally "employment agents," they usually can do the initial work more efficiently than an agency. Agencies earn their commission, often a high percentage of the first year's salary, on placing an applicant in a job. Consultants, on the other hand, usually charge on an hourly basis. Normally this means a lower charge than the agency commission. And there is not the constant pressure to have applicants presented to the doctors. Consultants can be more selective.

A consultant usually would spend a few hours in the practice talking with the doctor and seeing the office in operation. Often by having other practices to relate to and draw upon, the consultant will know better than the doctor what duties a manager should perform.

Individualized want ads would be designed to be placed into appropriate local newspapers. Resumes would be mailed directly to the consultant, thus keeping the physician(s) out of the beginning process. Only after reviewing resumes, telephone screening, initial interviewing and testing would the physician become involved in the hiring process. The consultant would do, in effect, the work described in the article last month, but on a higher level, doing more of an "executive search."

By removing most of the duties from the practice office and having the resumes sent to a blind post office box (or to the newspaper itself to be collected and sent to the consultant), the physician can refer all inquiries about the job "to my consultant." This may alleviate the need to interview and consider a patient or a friend who inquires about a job opening. Such encounters can be embarrassing for the physician who may not want to employ that person. If he were doing all of the search himself he would feel obligated to interview the person and embarrassed if he selected someone else.

Consultants also would have a better feel for the salary range for comparable positions in the local area, as well as what fringe benefits usually are provided. The consultant can direct the final interview with the physician present by asking questions to draw out the applicant. The consultant also can do the reference checking perhaps again having more experience than the physician.

Once the applicant assumes the responsibilities of being the new manager, some rapport and understanding already has been established with the consultant. The new manager may feel comfortable asking questions of the consultant about the practice and personnel. With the relationship already begun, it is easier for the two of them to work closely as a "team" on behalf of the practice.

A medical management consultant can play many roles in medical practices. The recruiting, testing, and interviewing of applicants for any job, but particularly for office manager or administrator, is just one.

If you are interested in exploring the possibilities of recruiting and hiring someone for your practice and you do not know how to go about it (or the position is such that your staff cannot handle it), check with your medical management consultant. The hours your consultant spends on your behalf will benefit you by producing the right employe for your office.

*The authors are the principle consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.*

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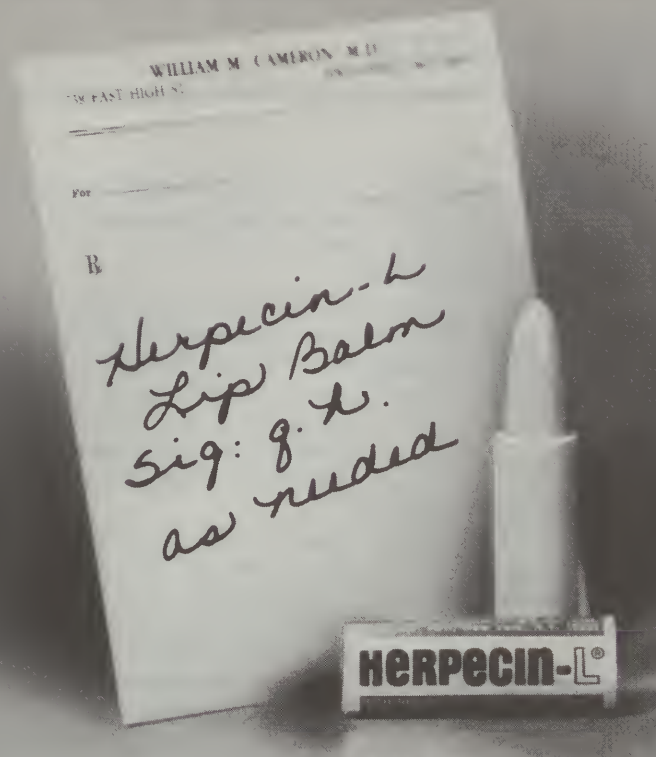


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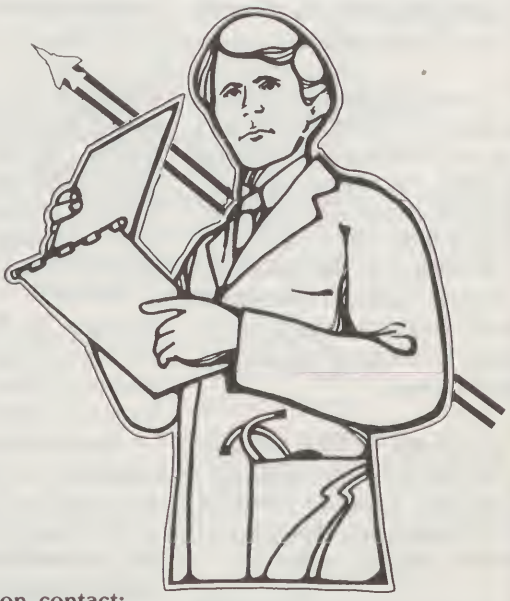

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# physicians in the news

**Marshall R. Metzgar, MD,** Jefferson Medical College 1922, recently retired after 56 years of private practice in Stroudsburg. An emeritus trustee of Lafayette College, he consistently devotes time and interest to higher education. Because of this and his humanitarian practice of medicine for more than half a century, he recently was awarded the honorary degree of Doctor of Laws from the college.

**Frederick Urbach, MD,** professor and chairman of the dermatology department of Temple University Health Sciences Center, has been elected to a four-year term as president of the Association Internationale de Photobiologie. Dr. Urbach is also medical director of Temple's Skin and Cancer Hospital.

The Society of Nuclear Medicine recently honored **Robert S. Fisher, MD,** and **Leon S. Malmud, MD,** with gold medals for their research. Dr. Fisher is professor of medicine and Dr. Malmud is professor of nuclear medicine and associate professor of medicine at Temple University.

**Luther L. Terry, MD,** former surgeon general of the U.S. Public Health Service during the Kennedy and Johnson administrations, has joined ARA Services, Inc. as corporate vice president for medical affairs. Dr. Terry had served for six years as vice president for medical affairs at the University of Pennsylvania and continues to serve as an adjunct professor at the university's medical school.

**George J. D'Angelo, MD,** recently gifted $1 million to Mercyhurst College to found the D'Angelo School of Music. Dr. D'Angelo is a thoracic and cardiovascular surgeon in Erie.

**Anna Marie Sesso, MD,** is the new medical director of Pennhurst Center. Dr. Sesso had been chairman of the pediatrics department at Mercy Catholic Medical Center, Darby.

**Sidney N. Busis, MD,** recently was honored as Israel's 1980 "Man of the Year" in Pittsburgh. Dr. Busis is in the private practice of otolaryngology. He is a clinical professor at the University of Pittsburgh School of Medicine and heads the otology division at Montefiore Hospital. He is senior staff member at Eye and Ear and Children's hospitals.

The Pennsylvania Association for Medical Education has named **Albert L. Lamp, MD,** president elect. Dr. Lamp is director of medical affairs at Saint Vincent Health Center.

*Psychiatry at the Crossroads,* a text recently released by Saunders Press, contains 13 essays which focus on controversial, important areas in contemporary psychiatry. The book is edited by **John Paul Brady, MD,** Kenneth E. Appel professor of psychiatry and chairman of the psychiatry department at the University of Pennsylvania and **H. Keith H. Brodie, MD,** professor and chairman of the psychiatry department at Duke University.

**Wilson A. Foust, MD,** recently celebrated 50 years of family medicine practice in the Lancaster area. In honor of the occasion, the Dr. and Mrs. Wilson A. Foust Scholarship Fund has been established at the Hahnemann Medical College.

**Herman D. Staples, MD,** recently was named president of the board of directors of the Parent Education and Human Relations Center, Media. Dr. Staples has a private practice in psychiatry at Media Clinic. He also serves on the staffs at Riddle Memorial Hospital and Philadelphia Psychiatric Center and as clinical associate professor of psychiatry at Hahnemann Medical College.

**Charles F. Miller, MD,** recently was elected to the board of directors of the American Cancer Society, Chester County Unit. Dr. Miller is chairman of the surgery department at Phoenixville Hospital.

The American Cancer Society recently honored **Donald Stader, MD,** with its Sword of Hope Award. Dr. Stader had been a volunteer for 33 years. He is a member of the state division's board of directors and is past president of the board and its Lehigh County unit.

**Peter C. Patukas, MD,** of Coatesville, recently was installed as the 146th president of the Chester County Medical Society. Other officers are **Drs. Nelson P. Aspen,** Paoli, president elect; **Raymond A. Rogowski,** Paoli, vice president; Norman A. Goldstein, Phoenixville, secretary; and William S. Lovrinic, West Chester, treasurer.

Two physicians were named Distinguished Pennsylvanians for 1980 by the William Penn Observance Committee. They are **Edgar L. Dessen, MD,** a Hazleton radiologist and **Graham H. Jeffries, MD,** chairman of the medicine department at Hershey Medical Center.

**Thomas C. Royer, MD,** has been named senior vice president and medical director at Geisinger Medical Center. Dr. Royer had been vice president and associate medical director under **Harry C. Stamey, MD,** who held the position until his recent death. Dr. Royer is director of Geisinger's emergency medicine department and the Susquehanna Poison Center.

**Joseph Mendels, MD,** recently was appointed medical director of The Fairmount Institute, a private psychiatric hospital in Philadelphia. Dr. Mendels had been professor of psychiatry, professor of pharmacology, and chief of the depression research unit at the University of Pennsylvania and Veterans Administration Hospital.

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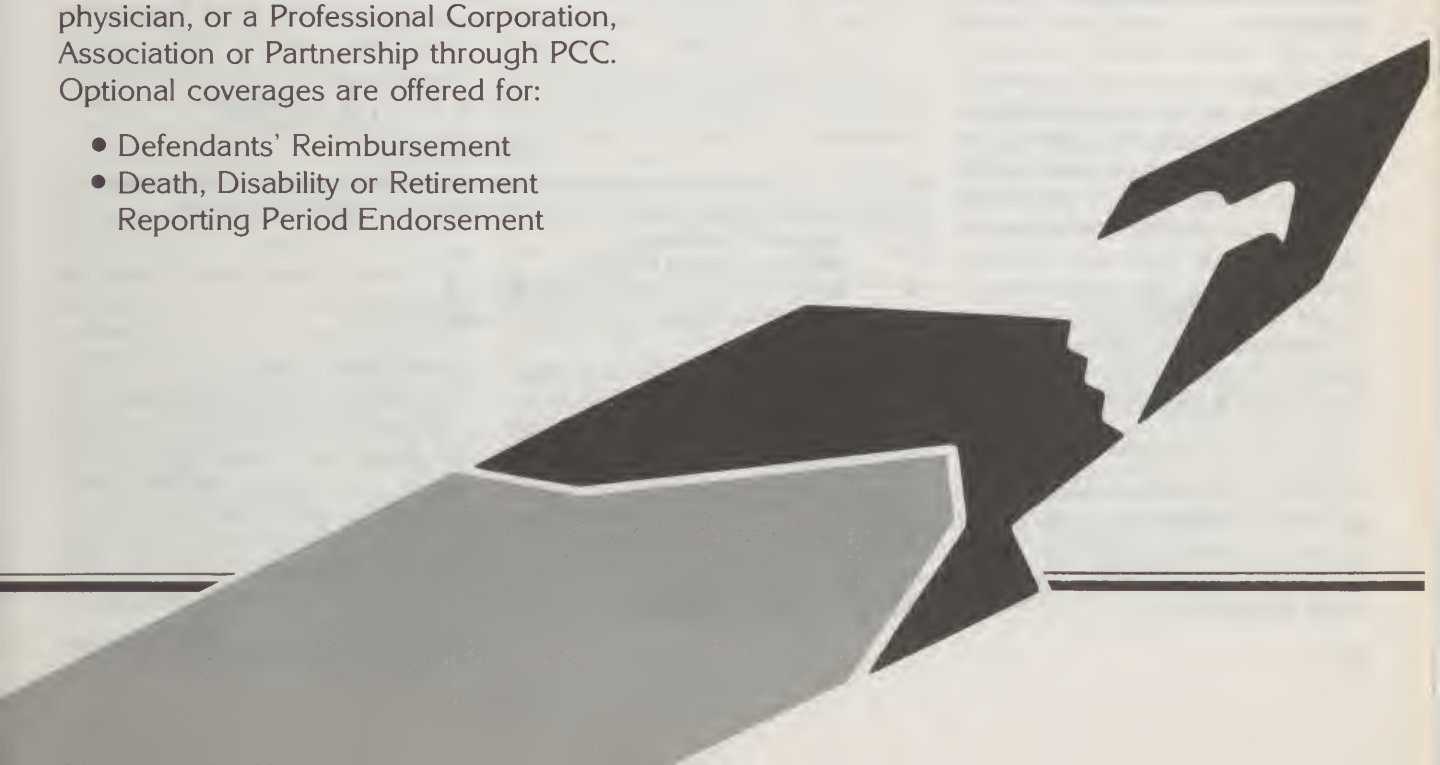

Case report

# Remission of hyperthyroidism by radiocontrast agent

Terry M. Kanefsky, MD
N. David Charkes, MD
Jesus Moctezuma, MD
Allan D. Marks, MD

Iodide containing radiocontrast agents can inhibit thyroid hormone secretion by virtue of their high iodide content.

Because the antithyroid activity of these agents is self-limited however, no clinical change in thyroid function can be detected in the majority of euthyroid patients who receive them. Even hyperthyroid patients, whose increased susceptibility to the antithyroid actions of iodides is known,[2] previously have not been reported to show even temporarily reduced serum thyroid hormone levels into the normal range after receiving iodinated radiocontrast agents.

In this report, a patient with clinically mild hyperthyroidism is presented. The patient's serum thyroid hormone levels were normalized after administering an iodinated contrast medium, thereby delaying the diagnosis and treatment of thyroid disease.

## Case report

A 52-year-old woman was admitted to Temple University Hospital on September 26, 1977 due to sudden onset of right-sided hemiparesis. Two previous strokes had produced debilitation complicated by exertional dyspnea, lightheadedness, and palpitations in the six months prior to admission.

During this same interval, she complained of mild anorexia. She also lost twenty pounds. She denied anxiety, irritability, or sensitivity to heat. Most of her symptoms were attributed to concurrent cerebrovascular disease and arteriosclerotic cardiac disease.

The patient appeared thin, pale, and chronically ill. Her blood pressure was 115/80mm Hg. The apical pulse was regular at 95 per minute. She did not appear anxious or hyperkinetic. Her skin was cool and dry.

Ophthalmic examination revealed no lid lag or exophthalmos. The thyroid gland was of normal size and no nodules were present. The heart was enlarged to palpation and a third heart sound and systolic ejection murmur were heard.

She exhibited an expressive aphasia

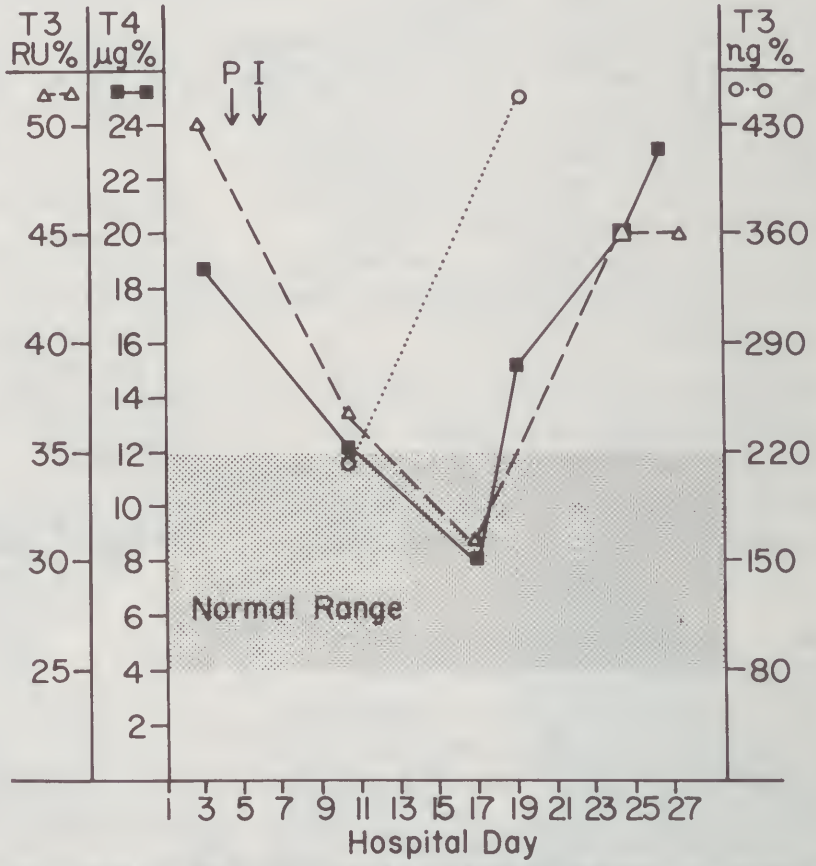


*Figure 1.* **Changes in serum thyroid hormone concentrations and T3 resin uptakes in a patient with hyperthyroidism exposed to an iodinated radiocontrast agent.**

| | |
|---|---|
| P | Potassium perchlorate |
| I | Iodinated contrast medium |
| T4 | Serum thyroxine concentration (■——■) |
| T3RU | Radioactive triiodothyronine resin uptake (△—△) |

*The authors are members of the endocrinology section of the medicine department and the nuclear medicine section of the radiology department at Temple University Health Sciences Center.*

and a right-sided hemiparesis. Deep tendon reflexes were hyperactive only on the stroke-affected side. No hand tremor was present.

No abnormalities were demonstrated in routine laboratory work. Cardiac hypertrophy was indicated on ECG. A serum thyroxine concentration (T4) was obtained soon after admission because her weight loss and tachycardia suggested the diagnosis of hyperthyroidism, despite the absence of other expected symptoms of this disease.

The low clinical index of suspicion for hyperthyroidism prompted us to pursue other studies, particularly relating to her neurological dysfunction, before we obtained the results of the serum T4 concentration. We administered 400 mg of potassium perchlorate immediately prior to performing a brain scan. On the sixth hospital day we performed a computerized axial tomography (CAT) study of the brain using 300 ml sodium diatrizoate (Hypaque-50$^{R}$, Winthrop), an iodinated contrast medium.

On admission, the T4 was 18 mcg% (normal, 4.5-12.5mcg%) and the triiodothyronine resin uptake (T3RU) 51% (normal, 25-35%). After receiving these unexpected results, we ordered additional thyroid function tests (Figure 1). The serum triiodothyronine concentration (T3), T4, and T3RU measured on the tenth hospital day (four days after the CAT study), were within normal range. On the seventeenth hospital day, they had decreased further.

On the nineteenth day, the T3 and T4 rose into the hyperthyroid range again. Thyroidal radioiodine uptakes performed at this time showed the $^{123}I$ uptake was 33% at two hours (normal, less than 12%) and 68% at twenty-four hours (normal, 9-36%). The thyroid scan showed diffuse, homogenous distribution of the isotope in a gland of normal size.

No change in radioiodine uptakes or in T4 occurred following the oral administration of 75 mcg of 1-T3 (Cytomel$^{R}$, SKF) daily for four days. This confirmed the diagnosis of diffuse toxic goiter. Accordingly, the patient then was treated with 5 mCi of $^{131}I$. Two months later the serum T4 and T3, and the radioiodine uptake were normal; the patient was clinically euthyroid.

## Discussion

In this report, the temporary antithyroid effect of the iodide contained in a radiocontrast agent delayed the diagnosis and treatment of Graves' disease. The initially elevated T4 was not reported until after the patient had received 300 ml of Hypaque-50$^{R}$ containing approximately 15 mg of free iodine. This dose of iodine exceeds that required to inhibit the release of thyroxine from the hyperfunctioning thyroid gland.[3]

Additional T4 levels determined over the next 17 days were within normal limits, suggesting an error in the initial T4 report, particularly in view of the patient's euthyroid appearance. Without making additional T4 determinations which again rose above the normal range, a serious delay in diagnosing Graves' disease may have occurred.

These iodinated radiocontrast materials are used frequently in clinical medicine, yet no instances of the unintentional normalization of previously elevated thyroid hormone levels have been reported in patients with hyperthyroidism who have received these agents.

Although our patient also had received a single 400 mg dose of potassium perchlorate, a drug with known antithyroid activity, it is unlikely that this agent contributed to the observed fall in serum thyroid hormone levels. Administration of multiple doses over several days' duration is required to obtain the degree and duration of therapeutic response noted in this case.[4]

## Conclusion

Patients in whom the clinical presentation of hyperthyroidism is subtle, or masked, require special attention. A normal T3 and T4 report may lead to the erroneous conclusion that, in fact, the patient is euthyroid.

Physicians who are aware of this potential complication of exposure to iodinated contrast agents, can take the proper precautions regarding the time when serum thyroid hormone determinations are made. In this way, unnecessary delays in the diagnosis and treatment of a potentially serious disease can be avoided.

## REFERENCES


1. **Burgi, H., Wimpfheimer, C., Burger, A., et al.:** Changes in circulating thyroxine, triiodothyronine and reverse triiodothyronine after radiographic contrast agents. *J. Clin Endocrinal Metab 43:*1203, 1976.
2. **Braverman, L.E., Woeber, K.A., Ingbar, S.H.:** Induction of myxedema by iodide in patients euthyroid after radioiodine or surgical treatment of diffuse toxic goiter. *New Eng J Med 281:*816, 1969.
3. **Volpe, R., Johnston, M.W.:** The effect of small doses of stable iodine in patients with hyperthyroidism. *Ann Int Med 56:*577, 1962.
4. **Godley, A.F., Stanbury, J.B.:** Preliminary experience in the treatment of hyperthyroidism with potassium perchlorate. *Clin Endocrinol Metab 14:*70, 1954.

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Pediatric health

# Poison control centers: services to communities

Mary L. Gricoski, MD
Cheston M. Berlin, Jr., MD

Accidental ingestion of potentially or actually toxic substances is a serious public health problem in the pediatric population, especially those children between 18 months and 3 years of age. In 1976 (the latest year for which data are available), 147,000 instances of accidental ingestion were reported to the National Clearinghouse of Poison Control Centers in Bethesda, Maryland.[1] It is estimated that the number of these cases is under-reported by a factor of 10. Accidental ingestion has been recognized as a major epidemiologic problem of pediatrics.

The establishment of poison control centers is an attempt to combat this problem. The model Poison Control Center (PCC) should be able to provide three major services: 1) toxicological information, 2) close association with a clinical facility for treating patients (including toxicological analyses) and, 3) educational programs in poison prevention and treatment methods for the professional and lay community which it serves.[2] Twenty PCCs in Southcentral and Southeastern Pennsylvania were surveyed to establish how they provide services for their referral community.

## Methods

Twenty PCCs in Southcentral and Southeastern Pennsylvania were site visited along with trips to the National Clearinghouse of PCCs (NCPCC) in Bethesda, Maryland and the Pennsylvania State Department of Health. The latter two sites were visited to learn prevailing opinion of desirable functions of PCC as well as national statistics on the incidence and type of ingestions.

Thirty-four staff members from 20 different PCCs answered the following questions in their personal interviews.

1. What toxicological retrieval systems do you use?
2. How many telephone inquiries do you receive per year?
3. What are your hours of service?
4. Do you report telephone inquiries to the NCPCC?
5. How are records of telephone calls kept?
6. Do you treat poisoned victims at your facility? Does your center have an established educational system for poison prevention?

A second phase of this study compared knowledge of poison prevention/treatment methods between two populations: one served by a rural group practice facility and one served by a referral medical center. The center has a poison control center supported and advertised by an active community service organization. Each facility has a comprehensive medical care program involving the family.

One hundred families (each with children under the age of ten) were selected at random from each institution's family care program. Each family was interviewed by telephone and asked the following questions:

1. What would you do first if your child accidently swallowed some poisonous material? (Try something yourself or call PCC for help)
2. Have you ever been faced with such a situation?
3. Have any friends or relatives ever experienced such a situation?
4. What emergency telephone numbers do you keep handy?
5. Do you know what syrup of ipecac is? If yes, do you have it in your home?

Results were analyzed using the Chi square method to the $p < .05$ level.

The protocol and questionnaires used in this study were approved by the Clinical Investigation Committee of the M. S. Hershey Medical Center (Protocol #467). Permission to interview each family was obtained from the family's physician.

## Results

All 20 PCCs use the text, *Clinical Toxicology of Commercial Products* (William and Wilkins Co., Baltimore), as one type of retrieval system for poison information. Nine out of 20 (45 percent) use the cardfile provided by NCPCC. The Poisondex[R] and Toxifile[R] systems are used by three (15 percent).

Toxifile and Poisendex are microfiche systems indexing toxicological information on drugs and compounds. They are revised several times per year and provide rapid retrieval of a large number of compounds. All centers used a standard reference text but only three used the complete microfiche retrieval systems.

A majority of the PCCs (11) received less than 500 telephone inquiries per year; 4 received between 500 and 1,000, and 5 received over 1,000 calls per year.

All 20 PCCs provide 24 hour service. Eight centers (40 percent) report phone calls to the National Clearinghouse of Poison Control Centers. Only

*The authors are members of the pediatrics department of the Milton S. Hershey Medical Center of the Pennsylvania State University College of Medicine.*

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five centers kept any records of calls received on their own institutional forms.

Only one PCC was not located at a medical care facility prepared to provide care for the poisoned patient. None of the 20 PCCs surveyed provided all of the services (information, treatment, and education) of an ideal center. Not one PCC provided education of both lay and professional personnel.

In the second phase of the study we were interested in the impact that a PCC might have on the population served by its sponsoring institution.

In both populations studied, the incidence of poisoning in families was identical. Twenty percent of each group of families said they had experienced an ingestion.

The first reaction in the rural based population was to try a remedy without consultation (59 vs. 36 percent for the referral center study group). Sixty-four percent of the population served by the referral medical center said they would call their PCC before starting therapy versus 41 percent for the rural based group. Both of these reactions were significant to the $p < .001$ level.

Nineteen percent of the rural center population had available the telephone number of a PCC; forty-five percent of the referral center's population had the number of their PCC ($p < .05$). The referral center's families had a significantly greater knowledge of the use of ipecac (51 vs. 27 percent, $p < .001$).

These answers indicate that the advertised presence of a PCC in an area will raise the level of awareness of its existence and function. But it also indicates that even in such a community, knowledge of basic aspects of poison control such as having syrup of ipecac and the telephone number of the PCC available is not nearly 100 percent.

### Conclusion

This study documents the current disorganized approach to the medical management of poisonings in one area of Pennsylvania. There is an increasing need for coordinating and consolidating PCCs nationwide to provide the most current information and treatment of ingestion. Continuing education of all lay and medical personnel clearly demands a major thrust; this crucial function was lacking in all 20 PCCs surveyed in this report.

Recent publications by many individuals and groups concerned with poison control have emphasized the need for regional organization to provide a network of highly sophisticated information centers which also will assume the responsibility to provide comprehensive treatment and education.[3] Education is the key to achieving the ultimate goal of preventing a medical problem which has been of epidemic proportion for years.

### REFERENCES


1. *Bulletin of the National Clearinghouse for Poison Control Centers.* February 1978, p. 1. U.S. Department of Health, Education, and Welfare, Public Health Service, Food and Drug Administration.
2. **Temple, A.R.:** Poison control centers: prospects and capabilities. *Ann Rev Pharmacol Toxicol 17:*215-222, 1977.
3. **Aldrich, F.D. et al.:** Poison-control centers. *New Eng J Med 301:*334, 1979.

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# Forehead weakness: a concomitant of hemiparesis

**Milton Alter, PhD, MD**
**Deborah Sichel, MD**

Weakness of facial muscles on the side of hemiparesis is recognized as part of the stroke syndrome. Usually, in such cases, only the lower part of the face is weak. The forehead muscles usually are spared because they receive an ipsilateral and a contralateral corticobulbar innervation.

Exceptions to the principle that the forehead muscles are spared with an upper motor neuron lesion are rare and only indirectly suggested in many neurological texts.[1-5] In the hands of less experienced practitioners, weakness of the forehead in cases of hemiparesis may lead to errors in diagnosis. To illustrate the exception, we present a patient with hemiparesis due to stroke. The forehead muscles on the hemiparetic side were weak despite their supposed double supranuclear supply.

## Case report

A 62-year-old, right handed male had difficulty opening a door and then apparently fell down eight to ten steps. Immediately he lost the ability to communicate or to move the right side of his body.

Examination showed a lethargic male with normal pulse and blood pressure. There was hemiparesis, hyperreflexia and a Babinski sign on the right. He had an expressive aphasia and responded only to deep pain on the right. There was a dense right field cut.

The patient was unable to follow a light introduced from the right. Hearing was intact. There was no difficulty in swallowing although hiccuping was noted shortly after admission. The right side of the face was weak and the right forehead had shallower furrowing, giving an "ironed-out" appearance. The forehead failed to move on attempted elevation of the eyebrows but the muscles of the left face moved normally.

Laboratory investigations revealed a white count of 20,500 with 80 percent neutrophils and 80 percent bands. The hemogram was otherwise normal. Serology for syphilis was negative. The blood urea nitrogen was 42 mg/dl and the sodium was 132 mg/dl.

A flow study brain scan showed decreased circulation on the left. The static nuclide scan showed increased activity in the territory of the left middle cerebral artery, compatible with cerebral infarction. A computerized axial tomogram revealed decreased density in the region of the left thalamus.

He was treated with Decadron. The level of consciousness improved and the hiccuping stopped. Premature ventricular contractions responded to Pronestyl. Transient hypertension was observed and treated with Hydrochlorthiazide. The weakness of the right forehead decreased over a two week period although the aphasia and severe right hemiparesis remained. Eventually, he was discharged to a chronic care facility.

## Discussion

Some authors note that the degree of forehead and eyelid paralysis with a contralateral supranuclear lesion shows considerable individual variation depending on the degree of bilateral cortical innervation.[6-9] DeMyer stated that with acute, upper motor neuron facial palsy, the eyelid is usually paretic.[7]

Physicians unfamiliar with contralateral control of facial movement below the forehead may think mistakenly that the patient with eyelid weakness has a lower motor neuron facial palsy. DeMyer did not comment on forehead weakness; however, Alpers and Mancall did mention contralateral forehead weakness acutely with a supranuclear lesion.[10]

How do some hemiparetic patients develop contralateral forehead weakness if forehead muscles are supplied from both motor cortices? One could postulate an aberrant pattern of corticobulbar innervation in such individuals. They may have a paucity of ipsilateral fibers and their main or exclusive corticobulbar supply to the frontalis and corrugator musculature could be contralateral. In such cases, weakness of the forehead would result contralaterally and disrupt the corticobulbar supply.

Hoff and Hoff concluded that in the chimpanzee, 20 to 25 per cent of the pyramidal fibers establish ipsilateral connections.[11] No adequate studies in man have elucidated the frequency of bilateral versus mainly contralateral innervation of the facial muscles. Strong mentions considerable variations in the percent of decussating fibers in man and, in extreme cases, the ipsilateral supply may be absent altogether. Conversely, in other cases, the pyramidal fibers of one or both sides may not cross at all and may give rise to huge, anterior pyramidal tracts.[12]

One may speculate upon the evolutionary significance of the suprabulbar supply to the facial nu-

*Drs. Alter and Sichel are members of the neurology department at Temple University School of Medicine.*

cleus. There is an advantage to having bilateral control of the forehead and orbicularis oculi muscles, while having mainly contralateral control of the muscles of the lower two-thirds of the face. Bing suggests that the bilateral cortical connection provides frontal and eyelid muscles with a means for synkinetic action.[2] Thus, the orbicularis oculi muscles normally contract simultaneously and both eyes are protected even when a threatening object is perceived by only one eye. The forehead muscles participate in this protective act by virtue of their bilateral cortical control.

In contrast, muscles of the lower part of the face (mouth and cheek muscles) are used in eating, mimicry, speaking, and conveying expressions where the two sides of the face are often used asymmetrically.[2] For this reason, bilaterally independent control of the lower part of the face is important and a different cortical control mechanism for the lower part of the face in man may have evolved. Indeed, the range of expressions in the mimetic muscles of man suggests an exceedingly rich, if not unique, cortical representation of facial movement.

Individuals with forehead weakness after stroke may represent a condition where contralateral cortical control has extended even to neurons in the facial nucleus destined for ipsilateral muscles. Following acute interruption of the contralateral innervation, the ipsilateral supply is transiently inadequate to activate these partially denervated cells.

## Conclusion

Our review of neuroanatomical sources revealed a surprising dearth of information on the cortical innervation of the facial nucleus, though surely the face must be the most frequently observed and diligently studied feature of the human anatomy. Cases such as the one we presented suggest that more neuroanatomical data on the facial nucleus of man are needed. Until more detailed clinical and anatomical information on innervation of facial and forehead muscles is obtained, instructors of neuroanatomy and clinical neurology should be less dogmatic about the invariability of contralateral forehead sparing with an upper motor neuron lesion.

## REFERENCES


1. **Wechsler, I.S.:** *Clinical neurology*, with an introduction to the history of neurology, 9th ed, Philadelphia, Saunders, 1963.
2. **Haymaker, W.:** *Bing's local diagnosis in neurological diseases*, 15th ed, St. Louis, C.V. Mosby Co., 1969.
3. **Vinken, P.J., Bruyn, G.W. (eds):** *Handbook of clinical neurology, Vols. 7-10*, New York, John Wiley & Sons, 1970.
4. **Gilroy, J., Meyer, J.S.:** *Medical neurology*, 2nd ed, New York, Macmillan Pub. Co. Inc., 1975.
5. **DeJong, R.N.:** Case taking and the neurologic examination, in *Clinical neurology*, Baker, A.B. (ed): New York, Hoeber-Harper, 1973.
6. Mayo Clinic: *Clinical examinations in neurology*, 4th ed, Philadelphia, Saunders, 1976.
7. **DeMyer, W.:** *Technique of the neurologic examination: a programmed text*, New York, McGraw-Hill, 1969.
8. **DeJong, R.N.:** *The neurologic examination, incorporating the fundamentals of neuroanatomy and neurophysiology*, 3rd ed, New York, Hoeber-Harper, 1967.
9. **Grinker, R.R.:** *Grinker's neurology*, 7th ed, rev by Vick, N.A., Springfield, Charles C. Thomas Publishers, 1976.
10. **Alpers, B.J., Mancall, E.L.:** *Essentials of the neurologic examination*, Philadelphia, F.A. Davis, Co., 1971.
11. **Hoff, E.C., Hoff, H.E.:** Spinal terminations of the projection fibers from the motor cortex of primates. *Brain 57*:454-474, 1934.
12. **Carpenter, M.B.:** *Human neuroanatomy*, 7th ed., Baltimore, Williams and Wilkins Co., 1976.



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**Emergency physicians** — Philadelphia and suburban Philadelphia hospitals. Fee for service with minimum guarantee, 42 hr. per week avg. Experience preferred but will consider all applicants. Contact Teddy Trout (215) 438-0390 for further details or send CV to EMSS, 5555 Wissahickon Ave., Suite L6, Philadelphia, PA 19144.

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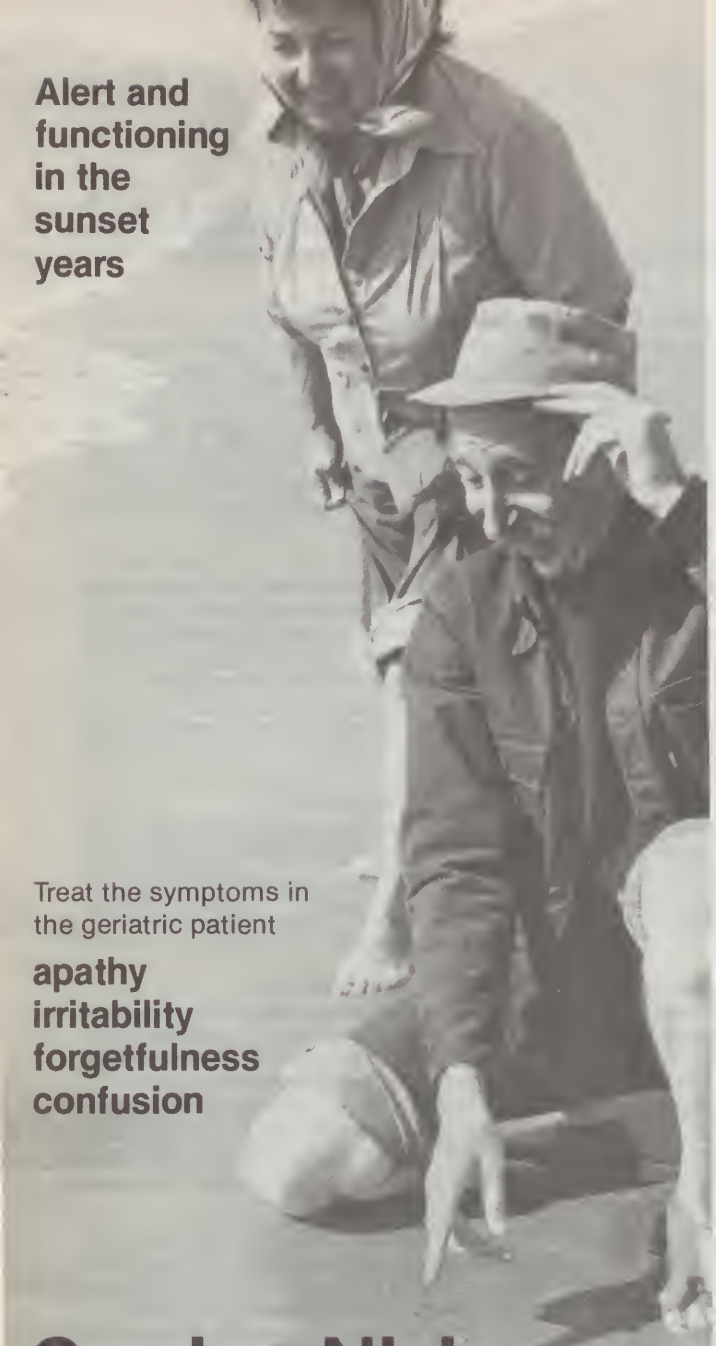

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# obituaries

• **Hjalmar S. Anderson,** Titusville; Johns Hopkins University School of Medicine, 1929; age 77, died September 7, 1980. Dr. Anderson had practiced surgery in Titusville since 1933 and was a former chief of staff of the Titusville Hospital.

• **Leigh Lobinger Darsie,** Rockwood; University of Pittsburgh School of Medicine, 1927; age 80, died August 25, 1980.

• **Isaak F. Gratch,** Birmingham, Michigan; Royal University of Bologna, Italy, 1919; age 88, died September 13, 1980. Dr. Gratch, a former Elizabethtown resident, had been with the public health service of Pennsylvania's health department from 1956 to 1972.

• **Frank M. Henninger,** Millheim; Temple University School of Medicine, 1937; age 74, died September, 1980. Dr. Henninger had a family practice in Millheim for 37 years.

• **Julius Margolis,** Coatesville; Temple University School of Medicine, 1930; age 75, died September 4, 1980. Dr. Margolis had practiced pediatrics and family medicine in Coatesville for more than 45 years.

• **Hermand F. Meckstroth,** Macungie; Jefferson Medical College, 1932; age 73, died September 21, 1980. Dr. Meckstroth had been medical director of the Elizabethtown Masonic Home and Hospital for 14 years before he retired in 1977.

• **Walter Stanley Nied,** Berlin, New Jersey; Temple University School of Medicine, 1921; age 84, died September 22, 1980.

• **Dan H. Persing,** Norristown; Temple University School of Medicine, 1936; age 72, died May, 1980.

• **Frank O'Neal Robertson,** Ford City; Jefferson Medical College, 1944; age 62, died September 2, 1980. Dr. Robertson had practiced medicine in Ford City and Kittanning since 1947. He was recently in charge of the emergency room at Armstrong County Memorial Hospital.

• **Henry P. Schwarz,** Philadelphia; University of Vienna, Vienna, Austria, 1925; age 81, died August 15, 1980.

• **Harry Clay Stamey,** Danville; George Washington University School of Medicine, 1952; age 52, died September 3, 1980. Dr. Stamey was senior vice president and medical director at Geisinger Medical Center since 1973. He was named president of the American Academy of Medical Directors in May of this year.

• **Roscoe W. Teahan,** Cherry Hill, New Jersey; New York Medical College, 1917; age 86, died September 3, 1980. Dr. Teahan was an oncologic surgeon and had been on the staff of Germantown Hospital for more than 50 years.

• **Henry Charles Thel,** Beaver; New York University School of Medicine, 1927; age 77, died September 4, 1980. Dr. Thel specialized in eye, ear, nose, and throat care, and facial plastic surgery.

• **Harry Williams,** Elkland; Jefferson Medical College, 1930; age 77, died September 2, 1980. Dr. Williams had practiced medicine in Elkland for 50 years. He was a 50-year member and past president of Tioga County Medical Society.

• **Frederick William Wright,** Hanover; University of Toronto, Ontario, 1923; age 83, died August 28, 1980. Dr. Wright was a surgeon in Hanover for more than 50 years. He was chief of staff of Hanover General Hospital from 1926 until 1977 and chief of surgery from 1926 until 1972.

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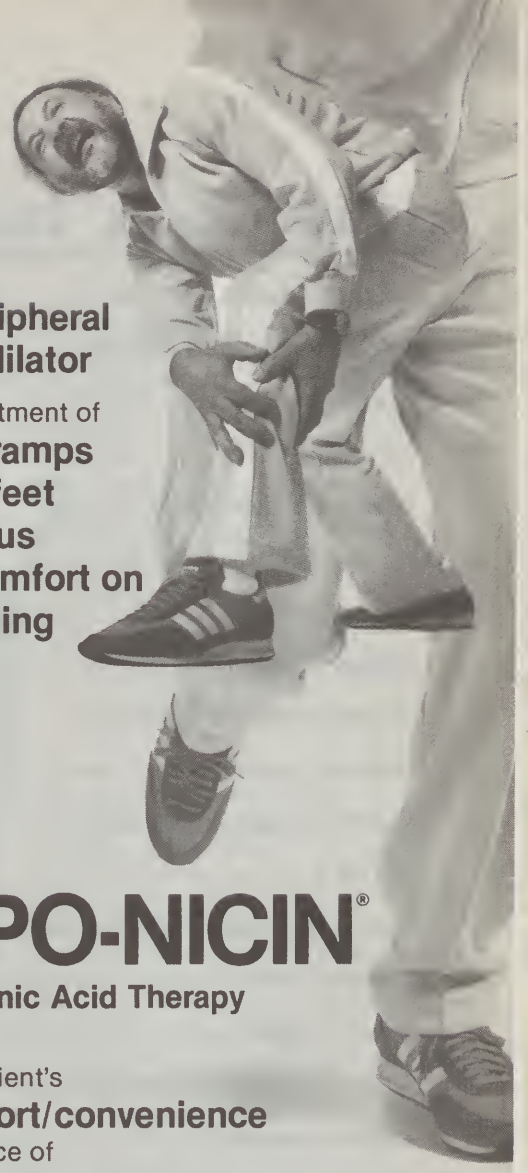

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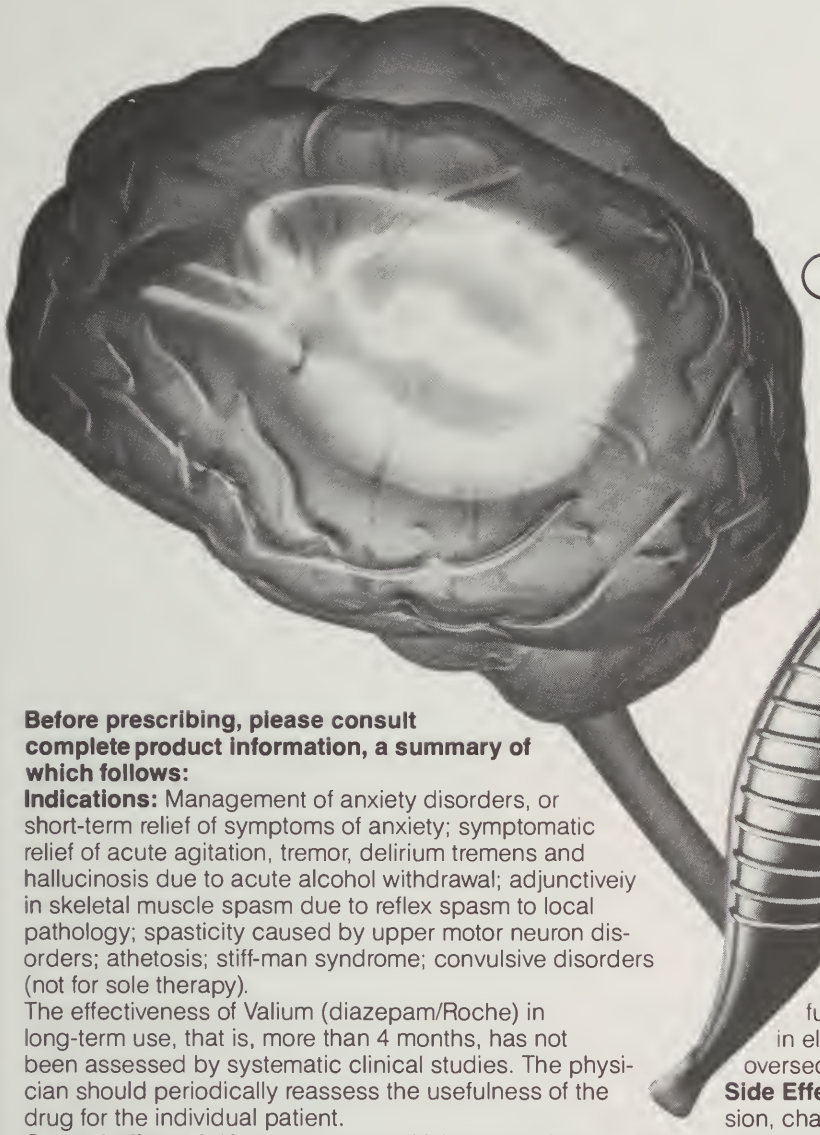

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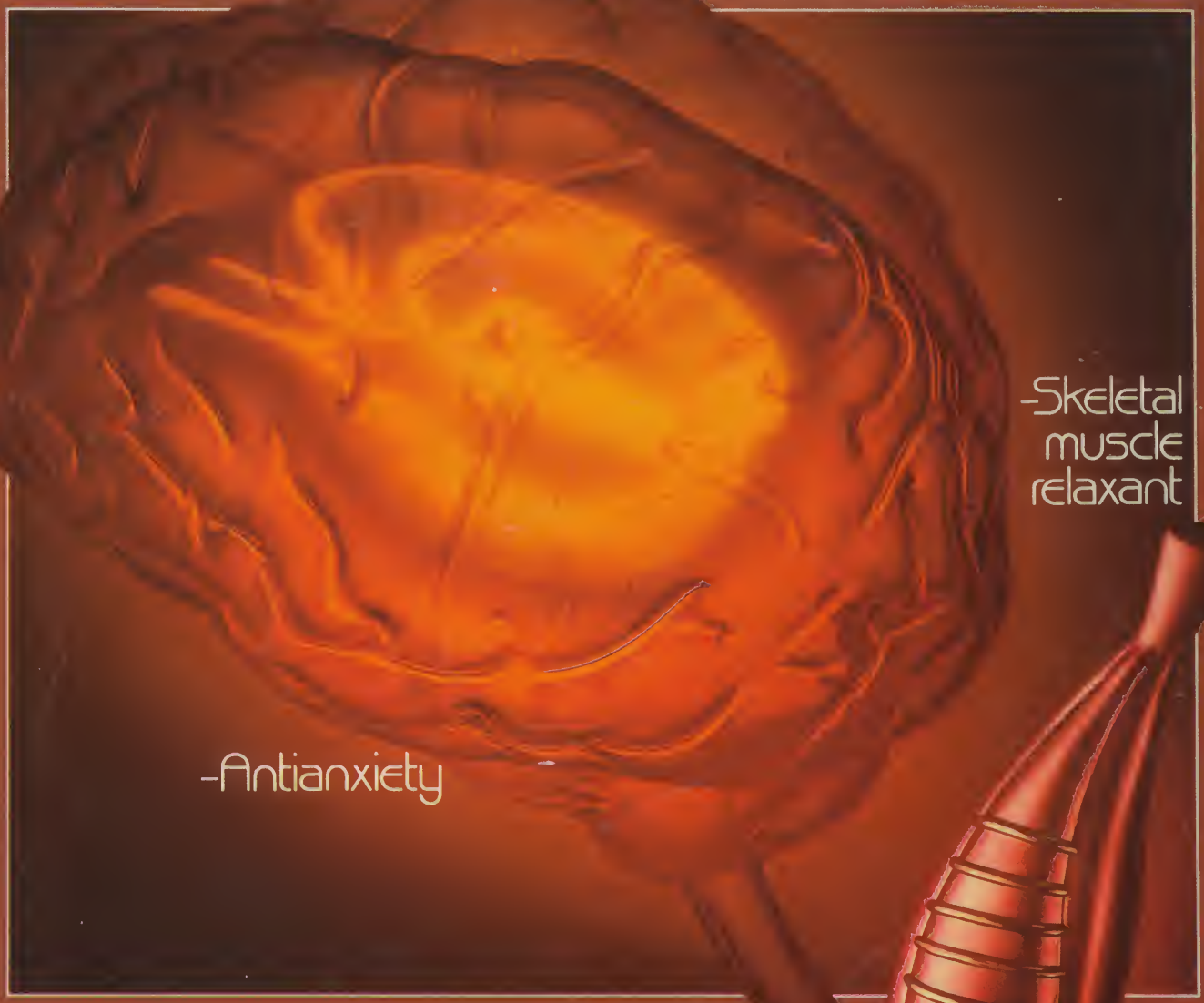

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Pennsylvania Medicine

Vol. 83, No. 12 DECEMBER 1980

# SEASON'S GREETINGS

# 1981

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1980

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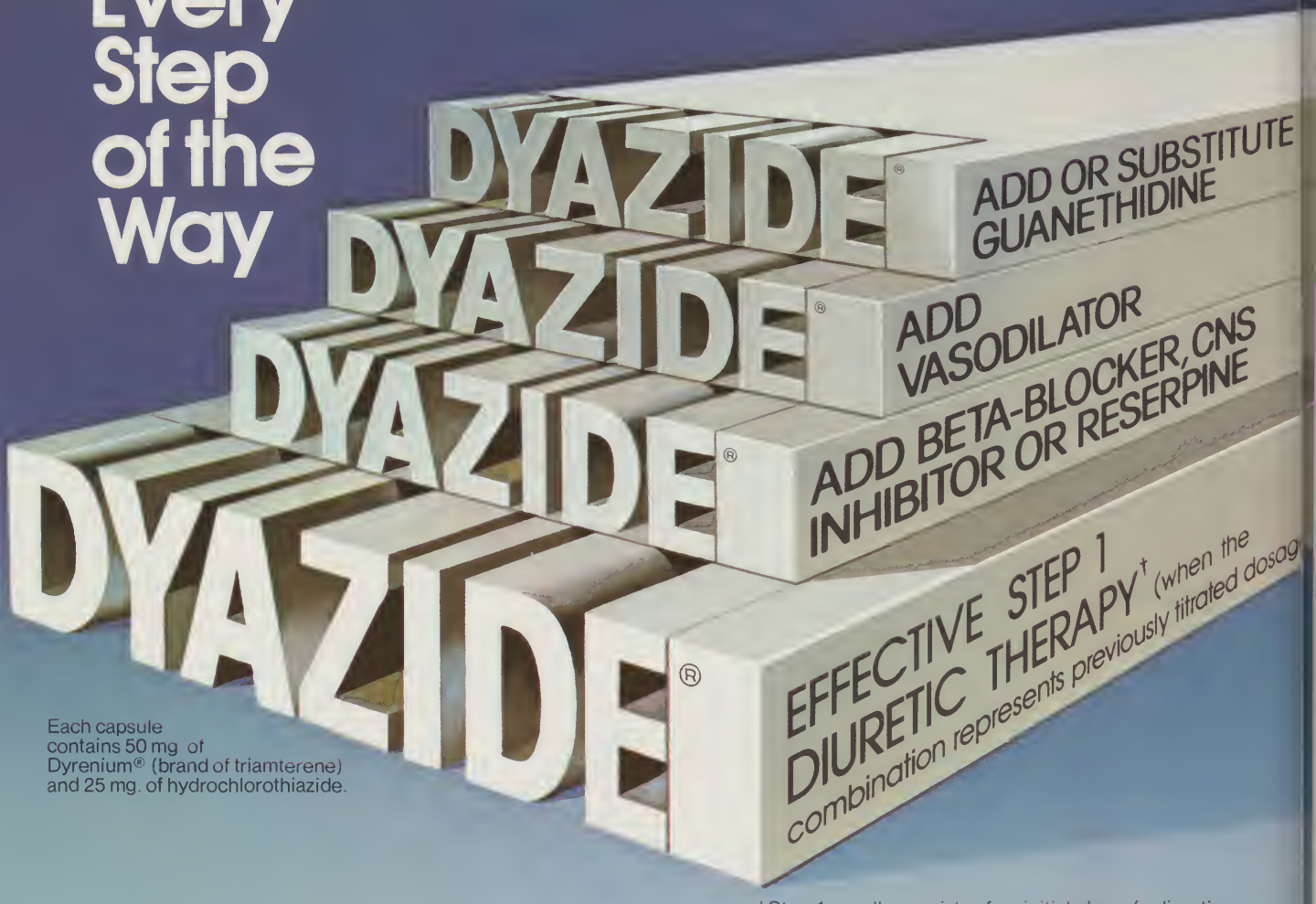
# Every Step of the Way




Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a $K^+$ supplement or $K^+$-sparing agent), and a maintenance phase (a diuretic alone or in combination with a $K^+$ supplement or $K^+$-sparing agent).

## Serum $K^+$ and BUN should be checked periodically (see Warnings).

**Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:**

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum $K^+$ frequently; both can cause $K^+$ retention and elevated serum $K^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

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# medigram

HOUSE OF DELEGATES ADOPTS NEW GOVERNING INSTRUMENT

As issues like medicaid reimbursement, the malpractice law, and abortion dominated the debate, delegates to the Society's 1980 annual meeting quietly and unanimously adopted new bylaws. The Philadelphia meeting of the House of Delegates October 31-November 2 also saw the election and installation of new officers (details on page 8). The new governing instrument is the result of almost three years of work by the Committee on Constitution and Bylaws. Committee members are: Drs. John Y. Templeton, III, chairman, Norman A. Goldstein, Wayne W. Helmick, Robert M. Jaeger, and Ralph J. Stalter. Betty L. Cottle, MD, a member of the AMA Council on Constitution and Bylaws, served as consultant. The June, July, and August 1980 issues of PENNSYLVANIA MEDICINE carried the complete bylaws proposal.

HOUSE OF DELEGATES OKs AMENDMENTS TO ACT 111

The PMS House of Delegates approved a proposed series of amendments to Act 111 (Malpractice Act) when it met last month. The amendments would (1) create a medical tribunal system to screen all cases and weed out non-meritorious claims; (2) create an alternative to the court system of adjudicating claims by providing for elective binding arbitration; and (3) modify the definition of expert witness and those sections of the law on the awarding of damages (Punitive damages would go to the Catastrophe Loss Fund. Lump sum award payments would be replaced by periodic payments spread over the lifetime of the injured party). The proposed amendments were a recommendation from the Board of Trustees and its ad hoc committee to consider amendments to Act 111. Henry H. Fetterman, MD, chairman of the ad hoc committee, testified at the reference committee hearing at the PMS meeting, and then on November 13 at a meeting of the Act 111 oversight committee, known as the "1006 committee."

"NO POLICY ON ABORTION" NEW SOCIETY POSITION

The 1980 PMS House of Delegates adopted a position of "no policy" and declared neutrality on the issue of abortion. The decision of the House followed lengthy debate at the reference committee hearing on three resolutions which became moot after delegates made the no policy decision. The Society's previous policy, which required documentation of medical necessity, was adopted in 1980 and debated at every meeting of the PMS House of Delegates since. The results of the membership survey on abortion, ordered by the 1979 House of Delegates and conducted last spring, were reported at the reference committee hearing.

MEDICAID FEE IMPROVEMENT PLAN OF ACTION MANDATED

Medicaid reimbursement and administration were overriding issues at the annual meeting. After much testimony at the reference committee hearing and debate in the House, delegates took the following actions:

1. Adopted a resolution that the Society continue to do all in its power to assure a uniform system of health care for all Pennsylvanians.

2. Told the Board of Trustees to prepare a concrete plan of action to upgrade medicaid reimbursement to private physicians and to publish the plan in PENNSYLVANIA MEDICINE within three months.
3. Order a feasibility study with Blue Shield and others on providing private health insurance for Medical Assistance patients.
4. Called on the governor and the legislature to investigate health professionalism in the administration of medicaid, and asked the state auditor general to investigate the MAMIS program (the new claim filing and provider payment mechanism of the welfare department).
5. Referred for study a resolution that starting in January 1982, all physician care of MA patients be discontinued in private offices and be donated in hospital clinics.

DUES INCREASE APPROVED BY HOUSE OF DELEGATES

The House of Delegates approved a $50 a year increase for full duespaying members, bringing the dues for that category of members to $275 for 1981. Other categories are increased proportionately. The Board of Trustees recommended the increase to offset a projected deficit in 1981 of $500,000. Finance Committee Chairman Kenneth L. Cooper, MD, presented the 1981 budget and cited inflation as the problem.

MEDICAL SCHOOL COSTS PROMPT HOUSE ACTION

Acting on a recommendation of President Leroy A. Gehris, MD, the House of Delegates ordered a study of the amount of dues allocated to the Educational Fund of the Educational and Scientific Trust. Dr. Gehris cited the soaring costs of medical education in recommending the study. The House also urged all members to make individual, tax-deductible contributions to the Trust. Also, 4.44 percent of each member's dues ($10 for each full duespaying member) will be allocated to the Trust in 1981. The Trust makes low cost loans to medical students (details on page 13).

TWO VOTING MEMBERS ADDED TO PMS BOARD

The 1980 House voted to franchise its speaker and vice speaker as members of the PMS Board of Trustees. Until now these officers have had a voice on the Board but not a vote. The House also adopted a recommendation that a representative of the Interspecialty Committee be made a member of the Board of Trustees. This recommendation was referred to the Bylaws Committee, which will prepare a bylaws amendment for action at the 1981 Annual Meeting.

AS AMA MEMBERSHIP GROWS PMS HAS TWELFTH DELEGATE

Pennsylvania will be represented by 12 delegates and 12 alternates at meetings of the AMA House of Delegates in 1981 (election results on page 8). One additional delegate and alternate were elected this year as AMA membership in the state increased. But for the second time in recent years the PMS House rejected unified membership mandating AMA membership for all State Society members.

MD LICENSURE FEE NOW $50, DUE 12/31

Despite action by the PMS House of Delegates, the biennial MD registration fee due December 31 will remain at $50. The state medical board voted a reduction from $75 to $50. The PMS House, however, noting the growth in the medical board's

reserve fund to over $3.6 million, called for a further reduction to the minimum possible. The House also pledged that PMS would continue its efforts to force the medical board to fulfill its disciplinary function, and to carry out the terms agreed to in the settlement of the PMS suit to enforce the Medical Practice Act. In a notice published in the Pennsylvania Bulletin on November 21, the medical board said time pressures and administrative costs made a further reduction impossible for this registration.

HOUSE VOTES OPPOSITION TO STATE-MANDATED CME

The House of Delegates reaffirmed the Society's opposition to government-mandated continuing medical education, including the Insurance Department's CME requirement, but voted to continue the CME requirement for PMS membership.

PMS BACKS IMPROVEMENTS IN MENTAL HEALTH SYSTEM

The deteriorating mental health system in Pennsylvania should be restored by reintroducing professionalism in the care of the mentally ill. This is what the House of Delegates voted when it adopted five resolutions of the Pennsylvania Psychiatric Society. The resolutions called for treatment teams headed by psychiatrists, treatment plans with physician responsibility, increasing salaries for psychiatrists employed by the state to a level paid by other states and private facilities, and re-emphasis of the PMS policy statement on physician-nonphysician relationships adopted by the 1979 House of Delegates.

STATE SOCIETY TO TEST NEW MEMBER PROMOTION

A membership promotion plan, designed to eliminate delays in processing new members, will have a two-year trial under the direction of the PMS Council on Member Services. In those counties in which the component society elects to participate, the State Society will screen prospective members, report findings to the component society, collect dues, and remit to the component.

LEGISLATURE PASSES PMS-BACKED HMO BILL

Greater participation by both providers and consumers in HMO development and operation in Pennsylvania is now possible. S.B. 1509 amended the Voluntary Nonprofit Health Services Act of 1972, bringing it into compliance with federal law, and permitting the organization of physician majority health maintenance organizations. Also passed in the last days of the session was S.B. 1367, repealing the "English Rule" and making it possible for physicians to countersue in malpractice suits without merit. See page 12 for a resume of 1980 legislation.

PENNSYLVANIA DELEGATION CARRIES PROPOSALS TO AMA

Five resolutions from PMS will be introduced to the AMA House of Delegates at its interim meeting in San Francisco December 7-10. They resolve as follows: (1) give the American Hospital Association a seat in the AMA House of Delegates; (2) oppose making permanent the Graduate Medical Education National Advisory Committee; (3) support an independent study of the federal health planning law; (4) establish rules for evacuation of bedridden patients in time of emergency; and (5) urge that a physician trained in psychiatry head a department of psychiatry in general hospitals.

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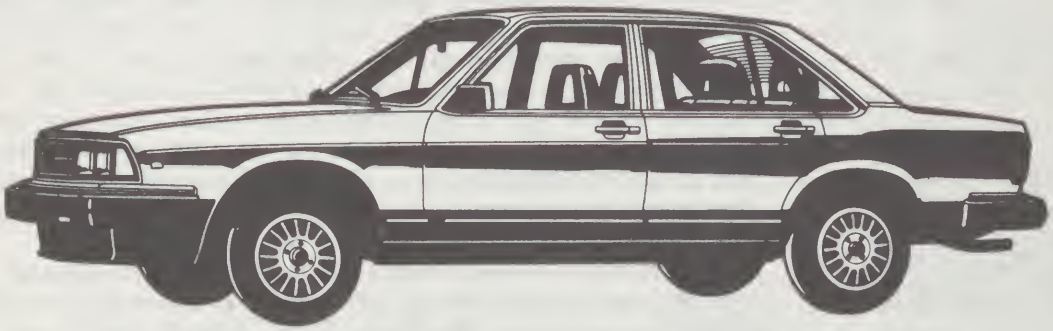

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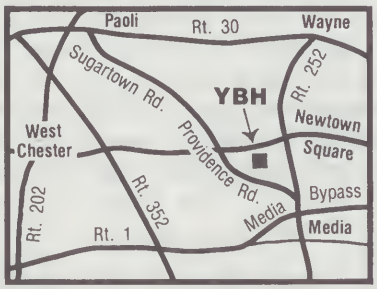


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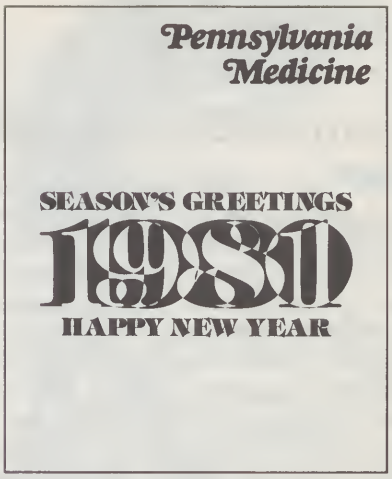


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PENNSYLVANIA MEDICINE
20 Erford Road
Lemoyne, Pennsylvania 17043
Telephone (717) 763-7151

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# editorial

## Continuing education—pro and con

In its report to the 1980 American Medical Association House of Delegates, the Council on Medical Education said that there is *no evidence that Continuing Medical Education* (CME) *enhances competence.* The House adopted this report and endorsed a cautious approach to mandatory recertification and continuing medical education.

At first glance, this appears to be a shocking revelation. Given some thought, however, the warning signs were there. The medical literature over the last several years increasingly has revealed a wave of discontent with CME, both in cost and quality. Editorials and correspondence have been even more pointed.

The acceptance by the medical community of a mandatory CME requirement fostered inevitably, the development of commercial CME programs. Glamorous trips coupled with minimal to nonexistent educational opportunities have been proffered. Other 'legitimate' medical education programs have carried exorbitant price tags, rendering windfall profits to sponsors, to organizers, and occasionally to lecturers.

Complaints have been recorded concerning time requirements. Most states and the American Medical Association require 150 hours every three years with at least 60 hours spent in "accredited sponsorship activities." Although 50 hours per year seems small, travel time and expense, loss of income, and overnight and meal accommodations multiply the impact of the requirement.

The distribution of credits in the five or six categories also has seemed less than fair to some. The amount of time, effort, research, and writing that goes into the oral delivery or publication of a medical paper for ten credits in category four seems insufficient.

Prior to adopting the mandatory CME requirement, most physicians attended at least one annual meeting per year of a society to which they belonged. Prior to the time when programs were not accredited officially, content, relevance, and evaluation were given minimal attention. Before CME, cost for the course was low.

In the change to a mandatory CME requirement, we have legislated something a large portion of physicians already did anyway and at the same time increased the administrative costs and official applications. This, in itself, does not mean that mandatory CME is not good. Additionally, it does not mean that CME *cannot* enhance competence.

Formal education is valuable to the individual when courses include practical information applicable to clinical practice. To fit this simple yet important criterion, the course need not be expensive nor far away. Accredited department meetings or grand rounds at your local hospital offer excellent opportunities.

CME is a good thing if it can be tailored to fit the individual's needs. In order for a planned program to be valuable, the attendee needs to participate, not sleep through the lecture or arrive late and leave early. Comments from the participants regarding content and suggestions for future programs need to be evaluated carefully by sponsors with the intent of providing a more desirable educational experience. CME boondoggles ought to be avoided and accreditation of such more closely monitored.

Finally, a re-evaluation of categories and numbers of allowable credits is in order. Since it is recognized that people learn in different ways, perhaps some method of evaluation of self-study can be found. Several specialty societies now offer home-study courses of excellent quality.

The credit for oral delivery or publication of a medical paper should be reconsidered and possibly made a category 1 activity. *In addition, the needs of semi-retired colleagues who want to keep a few patients, or retired colleagues who want to retain their society or association memberships must be recognized.*

It has been stated that there is *no evidence* that mandatory CME enhances competence. Although there may in fact be no evidence, it is difficult to believe that a truly conscientious physician does not glean at least some little practical information from a conference. Just because it is *not evident* is no reason to discredit our entire plan for CME.

Happy Holidays!

David A. Smith, MD
Medical Editor


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# House of Delegates sets new chain of command

Leroy A. Gehris, MD, of Reading, assumed the duties of the presidency of the State Society November 1, and a new chain of command was established. The House of Delegates elected Michael P. Levis, MD, Pittsburgh surgeon, vice president. Raymond C. Grandon, MD, of Harrisburg, moved from the vice presidency to become president elect.

Others elected to PMS offices during the 1980 Annual Meeting of the House of Delegates are: G. Winfield Yarnall, MD, Harrisburg, secretary; D. Ernest Witt, MD, Bloomsburg, speaker; Donald E. Harrop, MD, Phoenixville, vice speaker, Richard L. Huber, MD, Scranton, Third District trustee; and Carol N. Maurer, MD, Oil City, Ninth District trustee. The House of Delegates re-elected Samuel F. Cohen, MD, of Norristown, to the Society's Judicial Council, and Samuel S. Faris, MD, of Glenside, to the Committee to Nominate Delegates and Alternates to the AMA.

Dr. Levis, who currently is serving his second term as chairman of the Board of Directors of the American Medical Political Action Committee, will move up to the presidency elect in November 1981, and to the presidency in November 1982. A graduate of Notre Dame University and the St. Louis University School of Medicine, he received his residency training in general surgery at the Mayo Clinic. Dr. Levis is a past president of the Allegheny County Medical Society and is a Pennsylvania delegate to the AMA House of Delegates. He is a fellow of the American College of Surgeons.

The State Society's delegation to the AMA House of Delegates is expected to increase by one in 1981. Elected to fill the one-year term was David J.

The installation of Leroy A. Gehris, MD, 131st president

Michael P. Levis, MD, newly elected vice president

Still in the running, Immediate Past President Matthew Marshall, Jr., MD, in the second annual "fun run"

Raymond C. Grandon, MD, president elect

David J. Keck, MD, chairman of the Board

D. Ernest Witt, MD, speaker of the House of Delegates

David W. Clare, MD, vice chairman of the Board

Kenneth L. Cooper, MD, Finance Committee chairman

Donald E. Harrop, MD, vice speaker of the House of Delegates

Keck, MD, of Fairview, who also was re-elected chairman of the PMS Board of Trustees. Six delegates to the AMA whose terms expire at the end of this year were re-elected to two-year terms. They are R. William Alexander, MD, Reading; James B. Donaldson, MD, Philadelphia; Raymond C. Grandon, MD, Harrisburg; William J. Kelly, MD, Pittsburgh; Michael P. Levis, MD, Pittsburgh; and William Y. Rial, MD, Swarthmore.

Six alternate delegates were elected for two-year terms, and two were elected for one-year terms, one to complete the term of Dr. Keck, and one to fill the new opening because of growth in AMA membership. Those elected are: Gerald L. Andriole, MD, Hazleton; Betty L. Cottle, MD, Hollidaysburg; Joseph N. Demko, MD, Scranton; John L. Kelly, MD, Media; Jonathan E. Rhoads, Jr., MD, Philadelphia; and Irving Williams, III, MD, Lewisburg, Donald C. Brown, MD, of Irwin, and Charles A. Heisterkamp, III, MD, of Lancaster, will fill the one-year terms as alternates.

Those elected at the reorganization meeting of the Board of Trustees, in addition to Dr. Keck, were David W. Clare, MD, vice chairman; David A. Smith, MD, of Harrisburg, medical editor of PENNSYLVANIA MEDICINE; and Executive Vice President John F. Rineman, treasurer. Kenneth L. Cooper, MD, of Williamsport, was named chairman of the Finance Committee. A complete directory of Society officers and council and committee members will appear in the January 1981 issue.

## Dr. Gehris names five groups

# Board approves 1980-81 Council appointments

Upon the recommendation of Leroy A. Gehris, MD, the PMS Board of Trustees has approved the following appointments to administrative councils for the 1980-81 presidential term:

**Council on Education and Science**

Robert N. Moyers, MD, chairman (Crawford); Paul C. Royce, MD, vice chairman (Bradford); Gerald H. Amsterdam, MD (Philadelphia); Dean F. Dimick, MD (Lehigh); Victoria A. Gillis, MD (Armstrong); Michael A. Gross, MD (Lycoming); Robert G. Hale, MD (Montgomery); Arthur H. Hayes, Jr., MD (Dauphin); James J. Houser, MD (Venango); Richard P. Kennedy, MD (Monroe); S. Victor King, MD (Blair); Jay W. MacMoran, MD (Philadelphia); John A. Malcolm, Jr., MD (Union); Herbert C. Perlman, MD (Cumberland); George J. Racho, MD (Luzerne); R. Robert Tyson, MD (Philadelphia); Theodore L. Yarboro, MD (Mercer); William B. Yeagley, MD (Indiana)

**Council on Health Planning and Facilities**

Paul F. Kase, MD, chairman (Dauphin); Joseph V. Caliguiri, MD, vice chairman (Allegheny); R. William Alexander, MD (Berks); Doris G. Bartuska, MD (Philadelphia); Betty L. Cottle, MD (Blair); Joseph N. Demko, MD (Lackawanna); George R. Fisher, III, MD (Philadelphia); John G. Guthleben, MD (Erie); Webb S. Hersperger, MD (Cumberland); John J. Maron, MD (Montgomery); Robert M. Pilewski, MD (Venango); Ray G. Sarver, MD (Westmoreland); Robert D. Snyder, MD (Lehigh); John H. Wigton, MD (Delaware); Bernard B. Zamostien, MD (Philadelphia)

**Council on Legislation**

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The new council members' terms began November 1, 1980.

**The Joint Commission on Accreditation of Hospitals (JCAH) has a new 24-hour, toll-free Hotline number. It is 800-621-8007. The Hotline will provide responses to inquiries about the commission and the accreditation process. An operator will be available from 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday. Calls received at all other times will be recorded, transcribed, and returned on the next regular working day.**

## Dr. Young heads AHA state affiliate

Joseph M. Young, MD, recently was elected president of the board of directors of the American Heart Association, Pennsylvania Affiliate.

Dr. Young is an internist on the staff of Mon Valley Hospital. He has served as Affiliate vice president, chairman of the Assembly Planning Committee, and member of the executive committee and board of directors. Dr. Young received the Affiliate's Service Recognition Award in 1978.

Also elected during the Affiliate's annual Assembly in Philadelphia were Norman Makous, MD, president elect of the board of directors, and Drs. David M. Leaman, Robert C. Magley, and Mark E. Thompson, as the three vice presidents.

Robert F. Zelis, MD, Hershey, was honored during the Assembly for his outstanding leadership as 1979-80 president of the Affiliate. He received the Distinguished Service Award. Dr. Zelis is professor of medicine and physiology and chief of the cardiology division at Hershey Medical Center.

Physicians elected to the executive committee are Drs. Lawrence N. Adler, and Robert F. Zelis. Volunteers who will serve as directors-at-large are Claude R. Joyner, MD, Stephen B. Langfeld, MD, William H. Neches, MD, Constance A. Settlemyer, MD, and James A. Shaver, MD. Chapter representatives to the state board of directors for 1980-83 are Drs. Berel B. Arrow and William S. Frankl.

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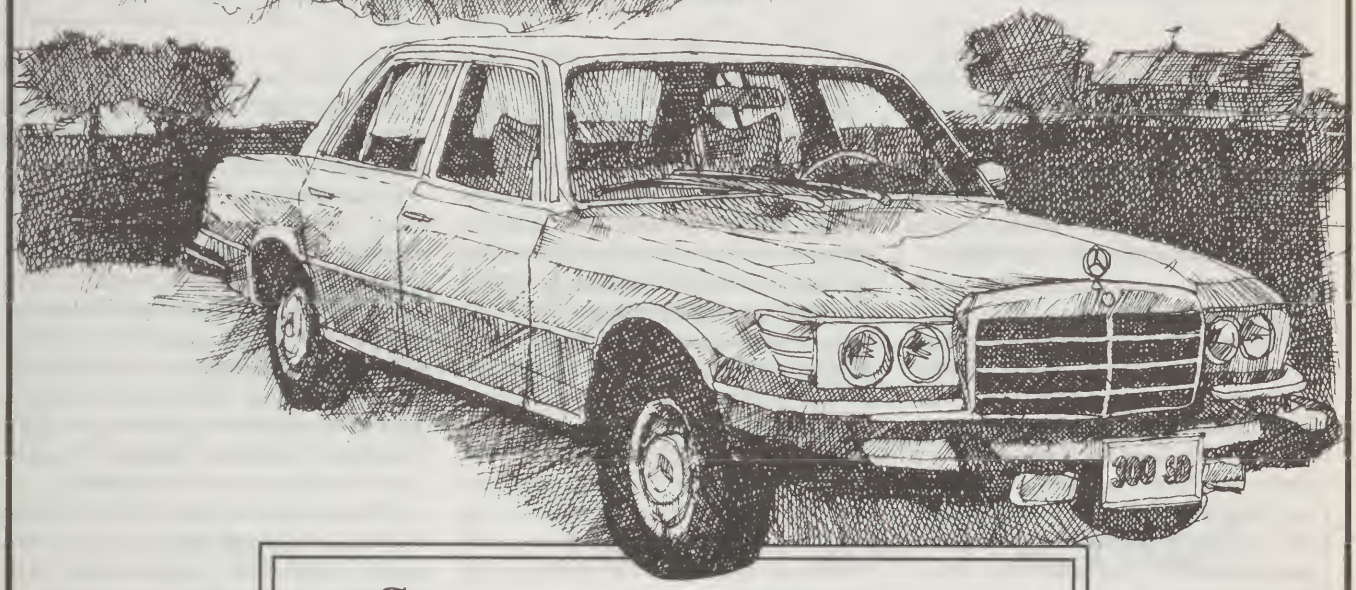


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Health legislation update

# Act 111 amendments, medicaid dominate

KathyLee Santangelo

Timing proved crucial in the two-year legislative session now drawing to a close. During the latter months of the 1979-80 session of the Pennsylvania General Assembly, much of the legislation of interest to physicians was the subject of legislative action.

**Medical malpractice**

For more than six months, the Society had supported House Bill 2204 which permitted the Catastrophe Loss Fund to pay claims brought before any legal jurisdiction. A provision in the Health Care Services Malpractice Act was interpreted by the attorney general to mean that the fund could only pay claims that had originated before the arbitration panels.

The Society redoubled its efforts to have H-2204 approved when, on September 26, 1980, the Commonwealth's Supreme Court declared the arbitration process under Act 111 unconstitutional. With the arbitration process eliminated, the CAT Fund could not provide coverage to physicians taken to court. Under the existing law, physicians had no CAT excess coverage for cases that did not originate before arbitration panels.

Governor Thornburgh signed H-2204 into law making it Act 165 of 1980 on October 15. For the time between September 26 and October 15, all the physicians in the state were, as far as the CAT Fund was concerned, "naked."

**Increased medicaid fee**

Governor Thornburgh presented his budget proposal to the legislature in February 1980. In it, he recommended that the fee for a physician office visit be increased from $6.00 to $8.00 in the Medical Assistance program.

When Matthew Marshall, Jr., MD, PMS president, testified before the Senate Appropriations Committee in March, he said, "The Department of Public Welfare is well aware of the inequities regarding physician reimbursement and their impact on costs in the Medical Assistance program. It is estimated that less than 45 percent of Pennsylvania physicians participate in the program because of the extremely low fees."

Secretary of Welfare Helen O'Bannon also testified before the committee in March. She told the committee that unless fees paid to all providers were increased, clients would not have anyone to turn to for care.

In May the Society launched an all member campaign asking physicians to contact their senators and representatives to raise physicians' fees in the Medicaid program. More than 2,300 lobbying kits containing lists of legislators and sample letters for the use of physicians and MA patients, were mailed.

The Society recommended these specific improvements in the budget:

- increase physician's office visit, brief examination, evaluation, and/or treatment from $6.00 to $15.00 and insert as a line item in annual Department of Public Welfare budget.
- change Department of Public Welfare policy to permit physician to bill Medical Assistance for a procedure or service in addition to an office visit.
- upgrade the Department of Public Welfare's entire surgical and procedure fee schedule to be in line with Medicare, and insert the schedule as a line item in the department's annual budget.

In its final version, the budget contained the increase in physicians' fees from $6.00 to $8.00 and the line item for physician office visits in the Medical Assistance appropriation.

**Podiatrists not physicians yet**

Senate bill 1160 would have changed the definition of physicians to include podiatrists except that the Society's strong opposition to the bill and the letters from physicians to members of the House Committee on Professional Licensure delayed the bill from being reported to the floor.

The bill is not expected to receive further consideration during the remainder of this session, but will probably recur in the next session.

**Blue Shield covers chiropractic**

Act 151 of 1980 permits Blue Shield to make available to its subscribers contracts which include chiropractic services, if requested, and at an appropriate increase in premiums. The Society opposed this bill.

**New laws**

Act 57 of 1980 is the New Optometric Act. The Society had opposed language in the bill that defined optometry as a "healing art" and "primary health care profession." This language is not in the Act. A clause which required optometrists to refer suspected pathologies to physicians was approved by the Society and was added in the Act.

Act 86 of 1980 requires that physicians' prescription blanks have physicians' names printed on them.

Act 105 of 1980 specifies Medical Assistance fraud as a felony for both providers and recipients.

# Trust loans $330,750 to neediest med students

Students entering medical school in the fall of 1980 faced tuition costs 240 percent higher than the cost of tuition for students of the class of 1978. According to the Educational and Scientific Trust of the Pennsylvania Medical Society aid for these students both from private and grant sources has not increased proportionately.

The Trust helped 165 of the neediest students who applied for loans through October 24, 1980. The Trust loaned out $330,750, but because of insufficient funds, it had to deny loans to 120 students. The Trust reports that the financial demands on a few students have been so severe that they may be forced to drop out of school.

Students who previously depended on Pennsylvania Higher Education Assistance Agency (PHEAA) loans to meet tuition costs faced a problem this year. PHEAA has a limit per medical student of $5,000 per year but there is not a medical school in the state where $5,000 will cover the cost of tuition. Hershey, where tuition is the lowest, costs $5,500.

Other problems were created when the 96th Congress failed to enact new health manpower legislation in time to benefit medical students in the 1980-81 academic year. For example, Chase Manhattan Bank, a participant in the Higher Eduation Assistance Loan (HEAL) program, froze all its loan monies as of September 30, 1980. The bank had been a source of loans as high as $10,000 to medical students. Chase suspended the program indefinitely for two reasons: the legislation authorizing guaranteed repayment of the loans was no longer effective, and the bank wanted to charge higher interest rates.

The Educational and Scientific Trust of the Pennsylvania Medical Society offers its loans at a 6 percent interest rate which is reduced to 4½ percent if the recipient establishes a practice in Pennsylvania. The interest rate on a new PHEAA loan is 9 percent. Banks making loans under a Robert Wood Johnson Foundation program are charging in excess of the prime rate. HEAL recipients are paying 12 percent interest on their loans.

The Trust has expended all funds available for loans to students in the current academic year. With additional individual support from you, the Trust will be able to continue to assist 49 fourth year students, 50 third year students, 37 second year students, and 29 first year students.

Send your tax-deductible contribution to the Educational and Scientific Trust of the Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043.

**Comparison of Pennsylvania Medical School Budgets for the years 1974-1975 and 1980-1981**

| School | Tuition | | Single Student | | Married Student | |
|---|---|---|---|---|---|---|
| | 74-75 | 80-81 | 74-75 | 80-81 | 74-75 | 80-81 |
| Hahnemann | 3,300 | 10,185 | 7,825 | 15,770 | 9,200 | 17,420 |
| Hershey | 1,500 | 5,500 | 7,100 | 13,255 | 8,990 | 17,135 |
| Jefferson | 3,000 | 8,800 | 6,550 | 14,428 | 8,010 | 15,988 |
| MCP | 3,350 | 8,850 | 7,250 | 15,495 | 8,950 | 18,400 |
| Pennsylvania | 3,580 | 8,615 | 7,100 | 15,000 | 8,650 | 17,600 |
| PCOM | 2,050 | 7,672 | 6,950 | 16,107 | 9,700 | 18,147 |
| Pittsburgh | 1,500 | 6,776 | 6,600 | 14,975 | 8,425 | 16,696 |
| Temple | 1,500 | 6,424 | 5,175 | 13,499 | 7,425 | 14,699 |
| Average increase over 7 years | | 241% | | 119% | | 97% |


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# Top leaders say planning for action essential

The Pennsylvania Medical Society is entering a new era of action by planning. At the opening session of the Annual Meeting of the House of Delegates on October 31, 1980, both the president and the president-elect focused their remarks on meeting the challenge of establishing long term goals and priorities.

Leroy A. Gehris, MD, in his address as president-elect, reported some of the findings of the all member survey conducted by Hay Associates of Philadelphia in June 1980. Dr. Gehris said that the survey showed "a key concern of members is that the Society continue and even expand its lobbying operations." Members also said that the Society should de-emphasize contributions to political candidates.

**Politics necessary**

Dr. Gehris pointed to the survey's finding that members fail to recognize the relationship between lobbying and political fund raising. He called political contributions, "an inescapable necessity" given the climate of special interest political action committees. He recommended "that PMS increase its allocation of resources and its efforts to educate members on the importance of PaMPAC."

Matthew Marshall, Jr., MD, in his report to the House, said that "special interest groups have replaced political parties as the power wielding force in our system. No single special interest group by itself can promote or halt legislation," said Dr. Marshall. "What is required is for special interest groups, groups whose separate purposes and goals on some issues may be very different, to unite in efforts to achieve goals which they have in common."

**Continue consumer rapport**

A pioneer in having the Society open communications with consumer groups, Dr. Marshall called the Urban League the Society's "best organizational link to the poor of both urban and rural areas." He recommended that the Society "continue to develop and expand open-minded communications with consumer groups." During his year as president, Dr. Marshall established the Pennsylvania Medical Society as a bona fide health consumer advocate.

Dr. Marshall also said that "the future belongs to those who prepare for it." He said, "Future planning should involve making the financial resources available to us work just as hard as they can to meet our goals." He recommended that the Society conduct all of its activities on the basis of work plans and budgets submitted to the Board of Trustees so that the House will be assured that the Society is spending enough for high priority goals and not spending too much on goals of lesser importance.

**Expand art of negotiating**

The importance of having a physician leadership prepared for the future was emphasized by Dr. Marshall. "Negotiation is the name of the game," he said. PMS must be one of the skilled players." He noted the achievements of the Act 111 ad hoc committee in keeping the CAT Fund solvent. He recommended that every member who interacts with other groups on behalf of the State Society become familiar with the principles of negotiation.

Dr. Gehris called on the Society to consider dealing with the potent force of a group whose "clout is growing commensurate with their numbers"—the senior citizens. He recommended that the Planning Committee examine the health issues facing the senior citizens of our state and suggest initiatives for their well being and the quality of their lives.

Dr. Gehris also recommended that the Society work toward improving the public image of the profession. He recognized the Auxiliary as the Society's most valuable allies and recommended that they be involved in plans to improve the physician's image.

He also recommended that PMS provides leadership in showing physicians how to adapt their practices to compete with new health care delivery systems and in teaching physicians new management and administrative skills.

**Medicaid "burning" issue**

In passing the highest office on to Dr. Gehris, Dr. Marshall alerted him to the burning issue of medicaid problems that he faced during the past year. Dr. Marshall said, "The fuel that stokes the fire in physicians' hearts is undoubtedly the knowledge that physicians are paid half as much for office visits as hospitals are paid for similar outpatient treatment. Further, physician reimbursement for all procedures is well below the usual and customary rate.

Dr. Marshall urged the delegates to "temper their anger and not let it interfere with progress" in negotiations between PMS and the Hospital Association of Pennsylvania, the Department of Public Welfare, and the Governor's office. He recommended that the Society continue to assign the medicaid problem a high priority. He also urged the Society to ask legislators to fight for a fair share of federal dollars for the state's medicaid program.

Another of Dr. Marshall's high priorities was that PMS monitor the actions of PSROs, state regulatory review bodies, and the Joint Commission on Accreditation of Hospitals. He reasoned that "wasting time complying with ineffective, inappropriate, or nit-picking programs defeats their purpose and demoralizes physicians who would support reasonable programs."

Dr. Gehris was installed as president and Dr. Marshall was awarded the Past President's Medallion at the state dinner November 2.

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# Court rules company doctor immune from malpractice

**Fred Speaker, Esq.**

The Pennsylvania Superior Court has ruled in a case of first impression that a full-time salaried plant physician is an employe and therefore is not susceptible to a malpractice suit by a fellow employe.[1]

An employe of the Bethlehem Steel plant in Johnstown was injured in the course of his employment and was treated by the defendant at the plant medical dispensary. The defendant worked for Bethlehem Steel on a full-time basis, was paid a fixed salary, was forbidden to engage in private practice, received the same fringe benefits as other supervisory employes, and had his hours and number of days worked controlled by Bethlehem Steel. After the injured employe died, the plaintiff instituted wrongful death and survival actions alleging negligence on the part of the physician.

The physician moved to obtain a summary judgment on the basis of the statutory provision that insulated him from civil liability since he was "in the same employ" as the injured worker. That provision, contained in the Workman's Compensation Act, provides that:

> If disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.[2]

The Superior Court rejected the argument that the physician was an independent contractor, stating that the fact that Bethlehem Steel does not control the manner of treating patients is not controlling. The Court concluded with the statement that:

> The determination of whether plant physicians and others in similar circumstances exercising independent professional judgment should be liable for their negligence must be left to the legislature. We therefore conclude that appellee was "in the same employ" as appellant's decedent and thus immune from civil liability for negligence under section 205.[3]

*Mr. Speaker is a partner in the law firm of Pepper, Hamilton, & Scheetz, which serves as the State Society's legal counsel.*

1./ *Babich, et al. v. Pavich, M.D., et al.*, No. 1459, Apr. T. 1978 (Pa. Super., filed Sept. 26, 1979), *appeal denied* Jan. 29, 1980.

2./ 77 P.S. §72.

3./ *Babich, et al. v. Pavich, M.D., et al.*, No. 1459, Apr. T. 1978, slip op. at 6 (Pa. Super. Sept. 26, 1979.

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# Fulfilling the requirements of informed consent

**Daniel J. Menniti, PhD, JD**

Commonwealth Court issued on November 14, 1979 an opinion which dealt succinctly with nontherapeutic sterilization, informed consent, Department of Public Welfare forms, and federal regulations governing the funding of sterilization as a family planning alternative.[1]

Sewickley Valley Hospital, Community Hospital, and Union City Memorial Hospital had requested reimbursement for five cases of voluntary nontherapeutic sterilization performed on medical assistance patients. There was no question that both Pennsylvania law[2] and federal law[3] provide for such reimbursement. At issue was whether the hospitals involved had complied with the regulations on informed consent.

The federal regulation states:

(2) As used in this paragraph:

(i) Informed consent means the voluntary, knowing assent from the individual on whom any sterilization is to be performed after he has been given (as evidenced by a document executed by such individual):

(A) A fair explanation of the procedures to be followed;

(B) A description of the attendant discomforts and risks;

(C) A description of the benefits to be expected;

(D) Counseling concerning appropriate alternative methods; and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure;

(E) An offer to answer any inquiries concerning the procedures;

(F) An instruction that the individual is free to withhold or withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care and without loss of other project or program benefits to which the patient might otherwise be entitled.[4]

The Department of Public Welfare published a two-part form entitled "Consent Document for Sterilization Procedure" in a memorandum explaining the federal restrictions on reimbursement for nontherapeutic sterilizations. The first part provided for the required federal elements for informed consent which contained provisions for the patient's signing of consent forms. The second part restated the elements of informed consent and provided a space for summarizing the details of the explanation given to the welfare recipient. This part was to be signed by the physician or his delegate who made the required oral presentation.

The hospitals in question had not had the second part of the form completed. Their representatives offered to supply evidence that the second part of the form was complied with but not filled out properly because of inadvertence or clerical error. The department refused to consider the evidence because it believed that the late submission would violate federal requirements for matching funds. The Commonwealth Court, with Judge Rogers dissenting, reversed the department's order.

The court, in the majority opinion of Judge Wilkinson, Jr., reasoned that the first part of the form was sufficient evidence of informed consent and that the second part constituted additional evidence of informed consent. It held that the department has the "authority to devise some mechanism . . . for verifying the existence of informed consent . . . (but disagreed) that such authority can extend to the point that its form . . . or at least its pre-submission completion (is) the exclusive means of verification."

The court stated that the burden for proving that there was necessary evidence of informed consent was that of the hospital.

Judge Rogers, in his dissent, said that the "only question raised in these proceedings is that of whether the Department of Public Welfare's rule is reasonable." He concluded that it was and stated that it was not a great burden for hospitals to comply with both parts of the form in question.

This deceivingly simple case warns all health deliverers of the necessity of proper informed consent *and* the evidence necessary to prove that such consent existed. As all physicians should know, the question of informed consent is basic to any practice of medicine and physicians and hospitals cannot be too careful in fulfilling all that proper informed consent requires.

*The author is associated with Pepper, Hamilton & Scheetz, legal counsel to the Pennsylvania Medical Society.*

1./ *Sewickley Valley Hospital v. Commonwealth of Pennsylvania, Department of Public Welfare, The Community Hospital v. Commonwealth of Pennsylvania, D.P.W., and Union City Memorial Hospital v. Commonwealth of Pennsylvania, D.P.W.*, ____ Pa. Comm. ____, ____A. 2d ____ (1979).

2./ 62 P.S. §443.1

3./ 42 U.S.C. §1396 *et seq.*

4./ 45 C.F.R. §205.35.

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# Depression: adults' most common psychiatric problem

**Harvy J. Schwartz, MD**
**Kenneth J. Weiss, MD**
**Thomas Wolman, MD**

The following group discussion took place as Drs. Schwartz, Weiss, and Wolman examined the diagnosis and treatment of depression by the primary care physician.

**Dr. Wolman:** Let us begin with the question: How does the typical depressed patient present in the primary care physician's office?

**Dr. Schwartz:** The typical patient with depression presents with certain clear-cut cardinal signs. At times, however, these signs need aggressive interviewing to elicit.

Classically, these typical signs of depression are called vegetative signs. They include sleep disturbance, appetite loss, loss of sexual interest, and loss of motivation and interest in worldly activities. The sleep disturbance often is one of early morning awakening. Usually the patient describes falling asleep without too much difficulty, but having trouble staying asleep.

The loss of appetite is a major complaint of many patients. Patients may remark that food does not taste the way it used to, or that they lack an interest in food. This can lead to significant weight loss.

In addition to these objective signs, a general mood disturbance is evident. It is a mood of sadness and pessimism about the future. Often it is described as helpless and hopeless. Self-criticisms and severe self-blame are characteristic. It is a picture of blueness that is often striking when first meeting a patient.

**Dr. Wolman:** Dr. Weiss, would you like to add anything?

**Dr. Weiss:** I wanted to add that depression is a well publicized entity. I think many individuals are conscious of depression and will diagnose themselves correctly. In the doctor's office, however, the patient may not complain of depression. He may complain of any number of presenting symptoms, for example, insomnia, not feeling like eating, difficulty in work or in school, or decreased motivation, such as Dr. Schwartz mentioned.

A married couple may come in presenting of increased quarreling or sexual dysfunction. Indeed they may have missed what we would see as a clinical diagnosis of depression in one of the partners. I think it is important to mention how common this problem is. Some figures are that 10 percent of the population at any one time suffers from clinical depression. It is the most common psychiatric problem in adulthood. Unfortunately 75 percent of the cases are undiagnosed and untreated.

**Dr. Wolman:** Dr. Schwartz, it is clear that many patients come into the primary care physician's office without a chief complaint of depression. Will you talk to us about this issue of masked depression?

**Dr. Schwartz:** Masked depression is an important clinical entity particularly to primary care physicians, some of whom report that it is the most common form of depression that they encounter. Simply put, masked depression is when a patient presents with a chief complaint that is other than feeling depressed. Often it can consist of various somatic complaints: headaches, backaches, G.I. upsets, or menstrual distress. When these patients are asked about their subjective moods they will not complain of feeling depressed. They will only mention the pain involved in their somatic complaints.

Some people feel that complaints such as anti-social acts, impulsive sexual behavior, temper outbursts, and periods of destructiveness also can represent masked depression. It is important to note that some clinicians consider some cases of alcoholism and other drug abuse to be part of the masked depressive picture.

Aggressive interviewing by the physician and a high index of suspicion often are necessary to reveal a de-

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*The participants are on the faculty in psychiatry and human behavior at Thomas Jefferson University School of Medicine. They also are on the staff of the Coatesville-Jefferson Program. This is the eleventh article prepared under the supervision of Dr. Wolman and the department of psychiatry at Jefferson as part of the series on office counseling for primary care physicians. The series is a project of the departments of psychiatry of the state's seven medical schools in cooperation with the Pennsylvania Psychiatric Society.*

Dr. Wolman

Dr. Schwartz

Dr. Weiss

pressive core and a depressed effect behind the somatic complaint. Most of the patients who present with this masked depression are between the ages of 30 and 60. Two-thirds of them are women.

Patients with true organic disease can have an exacerbation of their disease under the influence of a depression. Patients with ulcerative colitis, arthritis, asthma, or angina can all worsen under the stress of their depressive feelings.

Clues to the diagnosis of depression include a family history of depression or a personal past history of depression. Often the somatic complaints will have been preceded by environmental stresses. These patients characteristically are hard-driving, meticulous, and self-critical people. These traits often may be secondary to an underlying feeling of inadequacy. These patients, too, are noted to have a need to dominate which can make them challenging patients to work with.

Fortunately, these patients often respond dramatically to somatic treatment. There have been some reports recently of treatment with tricyclic antidepressants as well as with monoamine oxidase inhibitors. In addition to medication, careful supportive treatment is usually helpful. It is important for the clinician to feel comfortable and interested in dealing with these patients, otherwise, a referral may be indicated.

**Dr. Wolman:** The most important single issue that must be evaluated in the depressed patient probably is suicide and suicide potential. Dr. Weiss, what about the evaluation of suicide risk in the depressed patient?

**Dr. Weiss:** Yes, depression can be a lethal disease. Indeed, most depressions are accompanied by suicidal ideation which gets carried to one degree or another. In the United States the statistics show that about 11 in 100,000 die by suicide. This ranks the nation about midway among all countries in the world.

As far as evaluating for suicide and taking a history, I think first of all that it is a misconception that by the clinician's initiating a dialogue about suicide he is planting the seed of an idea in the patient's head. There is no question to me that initiating the topic of suicide can be life-saving. The depressed patient is frequently ambivalent about suicide and therefore will appreciate a frank discussion.

There are several things to look for when taking the history for suicide. One is the presence of depressed affect. The patient may feel hopeless, helpless, or worthless, or may even attain a sudden euphoria. This euphoria may indicate the patient's decision to do away with himself.

Other things to look for are recent life changes, particularly a history of recent loss or the anniversary of a loss. A personal or family history of severe depression or completed suicide or suicide attempts are additional risk factors.

Upon hearing that there is suicidal ideation, the clinician must get the details of any suicide plan. Again, it is crucial to be direct in questioning the patient about these ideas. The clinician must be alert to the patient's indirect communications, too. The patient jokingly may say, "If I had a gun I'd shoot myself," or "I felt like jumping off a bridge." Such off-hand comments are often the patient's only way of communicating the intent to commit suicide.

**Dr. Wolman:** Dr. Weiss, how would you bring up the issue of suicide with a patient in an interview?

**Dr. Weiss:** I usually take my cues from the patient. If the patient doesn't broach the subject himself, I'll ask a question such as, "Have things been so bad that you don't feel like living?" or "Have you had thoughts of ending your life?" I would be that direct.

Persistence is important too. Rarely is someone who is significantly depressed free from suicidal thoughts. If the patient had thoughts, then I would want to get an idea of how far he has pursued the ideas of suicide and how he intends to carry them out. I would go into such details as whether or not weapons are in the house or pills have been accumulated. I would want to know if the patient had been having

self-destructive impulses when driving or anything that may indicate a plan to harm himself.

**Dr. Schwartz:** One more factor that I think is particularly important for general practitioners is that many patients present with car accidents or some kind of life threatening accident that they do have some control over. I think we have to question whether some of these patients are not unconsciously acting out some depressed, suicidal feeling. I think that if physicians keep this in mind and pursue it, they may turn up a fair number of patients who, when a careful history is taken, often had a severe loss before their car accident or a disruption in a bond with a close person. Persistent and empathic questioning by the interested physician often can bring great relief to these troubled patients.

**Dr. Wolman:** Dr. Schwartz, what are some of the main medical conditions that you would want to rule out before arriving at the diagnosis of depression?

**Dr. Schwartz:** Although it is important to be aware of the many physical diseases and medications that can present with depression, it is also important to keep in mind that depression is not a diagnosis of exclusion. It has characteristic signs and symptoms and often a family history. A physician should not wade through a long list of esoteric medical diseases before starting aggressive treatment of depression. Time saved can be life-saving. Nonetheless, it is important to know some of the more common physical diseases that can mimic depression.

Hypo- or hyperthyroidism, and viral diseases such as hepatitis and mononucleosis are examples. In addition, depression can be the presenting complaint with an occult neoplasm, particularly pancreatic carcinoma, as well as any CNS space occupying lesion. The rarer diseases are hypo- and hyperparathyroidism, multiple sclerosis, and systemic lupus. Some recent work suggests that severe folic acid deficiency can aggravate depression.

Some drugs have depression as a side effect. Of course, they include all the antihypertensives, notoriously reserpine. Methyldopa (Aldomet) can present with depression and a lethargy. Guanethidine (Ismelin) has depression as a side effect and a widely used drug, propranolol (Inderal) can present both with depression and other signs of mental changes including psychosis. The steroids can present with a psychosis with any number of psychiatric symptoms. The new antiulcer drug, cimetadine (Tagamet) can present with depression and psychosis.

The psychotropic medications, the major tranquilizers, the antidepressants themselves, and most importantly, the minor tranquilizers such as Valium, Librium, and Serax, paradoxically can exacerbate depression in some patients. When the major or minor tranquilizers are prescribed mistakenly to patients suffering from depression, accurate diagnosis and treatment is delayed. This delay results in prolonged suffering for the patient and his or her family.

**Dr. Wolman:** What about depression in the elderly?

**Dr. Schwartz:** In the geriatric population, a careful differential diagnosis is increasingly crucial. In recent years, we have come to realize that many patients who previously have been diagnosed as demented, in fact, suffer from pseudodementia. Pseudodementia is reversible and treatable when diagnosed. Basically, it is when a patient presents with signs of dementia, but, in fact, is suffering from a depression like masked depression. These patients are responsive to somatic treatments including medications and in some cases electroshock treatment.

Some precipitating losses in the lives of these patients include other physical ailments and disabilities such as loss of vision or hearing. Certain key clues in the differential diagnosis include a personal or a family history of depression, recent losses, and finding that the patients lack the shallowness and indifference that are often part of genuine dementia. In cases in which accurate diagnoses are impossible on clinical grounds alone, careful titrated use of an antidepressant may be valuable in securing a diagnosis, a response, and a relief of pain.

**Dr. Wolman:** A problem that confronts the practicing clinician almost daily in his clinical work is when a patient presents with a picture of both anxiety and depression. How can the doctor differentiate the two and determine which is more important? What kind of somatic treatment is most useful for that particular patient?

**Dr. Weiss:** Anxiety and depression often are intermingled. My advice would be to try to make the diagnosis of depression and treat it as such. In the case of anxiety secondary to depression, I would suspect that treating the depression adequately automatically would relieve the anxiety.

Another point is that the antidepressant medications frequently have sedating properties which can add an

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antianxiety component. I think, however, that in the case of an anxious depression it would be a mistake to treat the anxiety along with a minor tranquilizer like Valium. In doing so, you would miss the depression which would otherwise be treatable. As mentioned already, the patient then would be subjected to a protracted bout of depression and all the accompanying difficulties.

**Dr. Schwartz:** I would like to emphasize Dr. Weiss' comment about how important it is to diagnose the depression especially in the patient with anxiety. I cannot count the number of patients whom I have seen on referral who often have profound depressions and report being given one of the minor tranquilizers by their family doctor. This has resulted in delayed treatment. In some cases in the literature, it has resulted in an aggravation of the depression leading to suicide.

This leads us into the question about which, if any, medicines should be used in the treatment of depression. Medications are indicated when the depression is accompanied by severe vegetative signs. In select cases, supportive or insight psychotherapy can help the patient unravel the pain he is experiencing.

The first time drug almost universally is agreed to be one of the tricyclic antidepressants. The two most well known tricyclic antidepressants are amitriptyline (Elavil) and imipramine (Tofranil).

Deciding which drug to use may be difficult. Amitriptyline is more sedating and more anticholinergic than imipramine. Neither has been shown to be more effective in treating depression. Usually the selection is made on the basis of the drugs' side effects.

With both of these medicines as well as the other tricyclics there is a 70-75 percent response rate when used in adequate doses. The average dose for the 70 kilogram man is 150 mg. Patients rarely respond completely to a lower dose. Higher doses often are needed. Under-medicating has always been a serious problem and continues to be a significant cause of treatment failure. Often upon referral, all that the psychiatrist does is raise the 50 mg of tricyclic that the patient was getting to 150 mg and there is a complete response. This shows that, in fact, primary care physicians readily can manage most depressions.

**Dr. Weiss:** There is a great deal of research in psychiatry regarding antidepressant drug choice in various clinical conditions. I think before too many years we will have biochemical tests which may tell us which antidepressant to use in each patient. We are discovering that the drugs have differential effects on various central nervous system neurotransmitters. Until that time, however, I think the rule of thumb is that the clinician should use the antidepressant medication he is most comfortable using in terms of its beneficial and adverse effects.

**Dr. Wolman:** Is there still a place for electroshock therapy in the treatment of depression?

**Dr. Schwartz:** This is certainly a controversial area that has become a political football in certain parts of this country. I feel it is important to remember that of all the somatic treatments for depression, electroshock is the safest and it has the highest efficacy. There are fewer deaths reported in a group of depressed patients who were treated with electroshock than in a similar group of depressed patients who were treated with medications. Its onset of action is rapid and in that way it can relieve someone from suicidal distress.

**Dr. Wolman:** What role does psychotherapy play in the treatment of depression?

**Dr. Weiss:** A supportive, nonjudgmental stance by the clinician is extremely important in treating any sort of depression. The milder forms of depression can and should be treated entirely with psychotherapy or office counseling. The clinician should transmit in his attitude toward the patient understanding and comprehension of suffering. I think from the patient's point of view, the feeling of being understood and being taken seriously can be an important ingredient in successful interventions. I think that the clinician should transmit the idea that he is available and warm, but that he does not necessarily share the patient's depression.

**Dr. Schwartz:** Choosing between medications and psychotherapy is a difficult decision. How to treat patients is a controversial area, yet everyone agrees that some patients should be treated solely with psychotherapy. There are other patients who almost everyone would agree absolutely need medication, but the vast majority of patients fall somewhere in between.

The decisions for treatment often are based on theoretical biases. They are not the results of controlled studies. When this question has been studied it has been found that psychotherapy treats a different part of the person than medication. Medication is directed specifically at symptom relief. Psychotherapy can help the person's overall coping, his functioning, and his comfort with himself.

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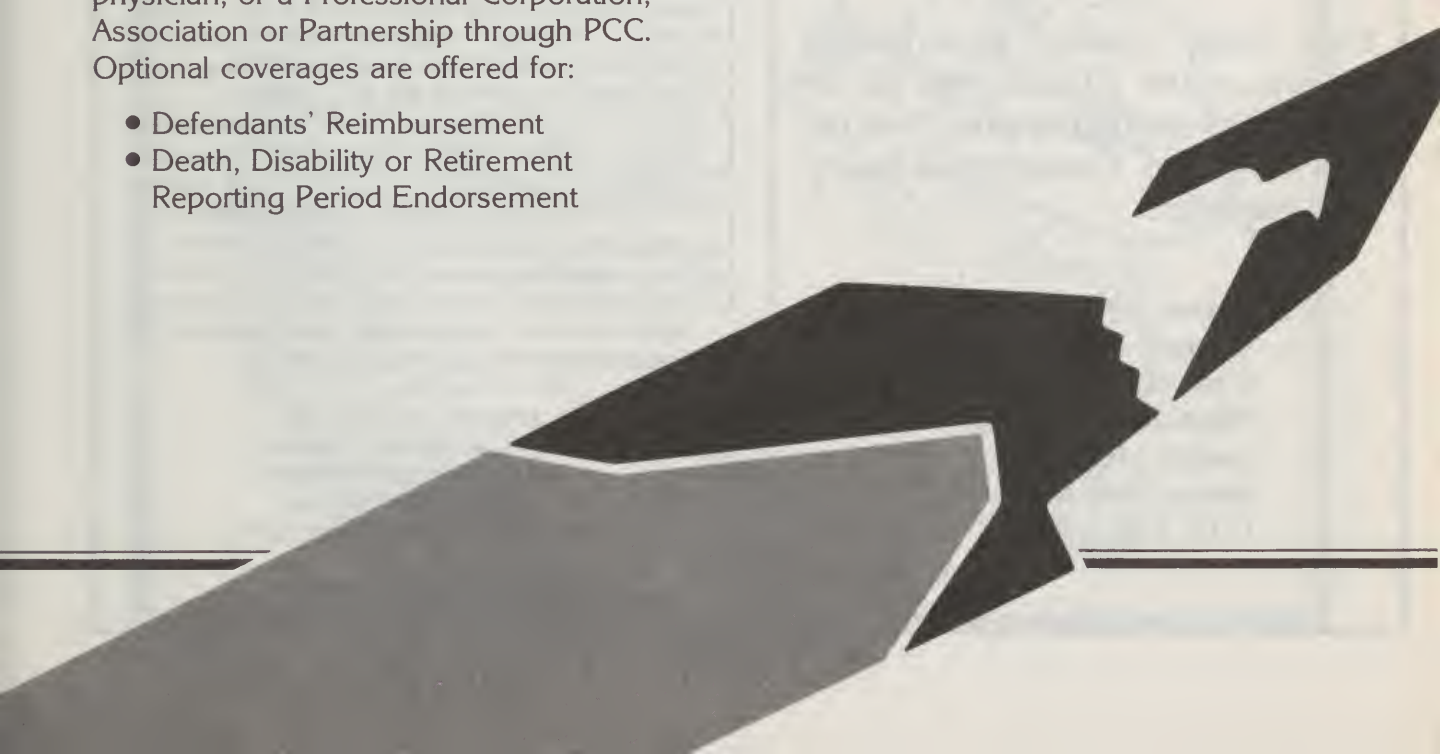

# in my opinion

## The Child's destiny

Once a Child was born. In many ways He was the same as hundreds of other children born during that same hour. During that same day many more thousands of children were born over the world. The Child's skin was dark. It may have been black, or yellow, or red. The color should not have made any difference, but it did.

The Child had parents and grandparents and great grandparents. He may have known only one of them, or many of them, or none of them. His body, mind, questions, quickness, and smile all depended upon His mother and maternal grandparents. These attributes depended upon fortuity, for many thousands of random gene matings contributed uniqueness to His body and mind. The fortuitousness of ancestry, of heredity, of gene mingling, should not have made any difference, but it did.

The paternal side of the Babe's ancestry was somewhat unusual. It was divinely accomplished by an overshadowing (Luke 1:35). No gene mingling, no heredity, no fortuity was involved in the Babe's paternal ancestry.

The Child was born in a specific place. The place may have been the palace of a king, the court of a wealthy landowner, or the homey familiarity of a working man's home. The place was none of these. It was a cave reserved for animals.

It may have been West, North, or South, but by divine design it was in the East. The place was identified many years before the event occurred (Micah 5:2). The place of birth should not have made any difference, but it did.

The events surrounding the birth of this particular Child, born nearly 2,000 years ago, are among the best documented and most widely accepted ancient birth records available today.

As with other children, this Child grew and learned. He learned from being with others and also from being alone. He may have learned more in His aloneness, but He was wise beyond His years (Luke 3:30, 46, 47). Growth occurred, for children have always grown. And always for children there is a beginning and a becoming.

The most famous school of Greek philosophy flourished for about 300 years and included Socrates, Plato, and Aristotle. Some of their ideas are still remembered and quoted. Yet they pale in contrast to the teachings and tenets of the Child we are discussing. Few poems, sparse literature, and not much music was inspired by the Hellenic philosophers, at least in terms of the quality and quantity of music, poetry, and literature inspired by that unlearned Man who, for three years taught a band of poorly educated commoners.

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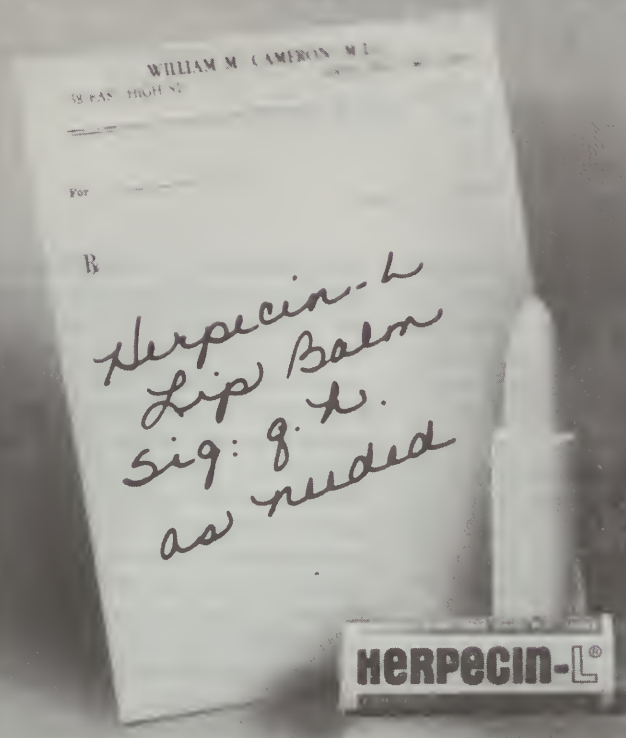


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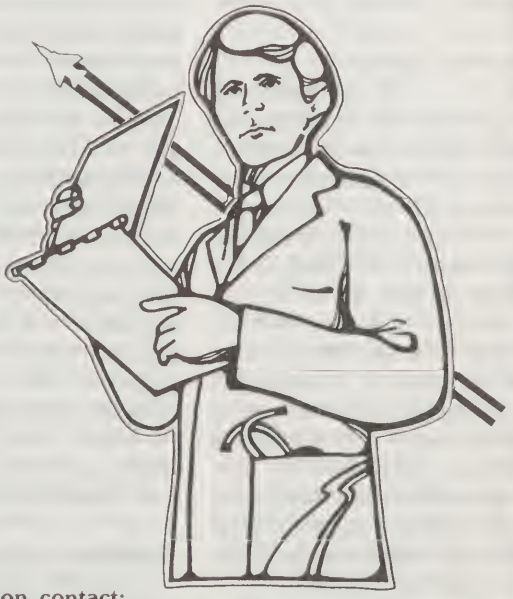

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# Hints for the hiring season: Dr. New and you

Leif C. Beck, LL.B., CPBC
Vasilios J. Kalogredis, JD, CPBC
Geoffrey T. Anders, JD, CPA
Dorothy R. Sweeney

Fair arrangements between a senior physician or existing group and a young doctor joining with him or them are the subjects of many inquiries from physicians. Both sides are curious. The hiring side wants to know what should be offered, and the doctor just finishing residency wants help evaluating a prospective practice.

Our new sample hiring letter reflects the changes in the supply and demand of physicians as we discussed in our June, 1980 article. However the details of the hiring arrangement are agreed, *they should be in writing between the parties to avoid any possible misunderstandings or embarrassments.*

We do not consider a fancy legal document as important as the letter written by a physician to a physician. The physicians are the ones who must understand their relationship. For this reason, our accompanying "Dr. New Letter" may prove useful in this hiring season.

### Short term economics

Although the employing doctor or group invariably seeks an additional physician for long term considerations (to handle the increasing patient load, to share responsibility, review, coverage, etc.), the employer is becoming increasingly aware of the likely short term effect on his own net income.

Firstly, the cost of hiring another physician will be considerably more than the agreed salary. If, for example, a package of employe benefits (many of which are discussed in later sections of this article) is offered to the new physician, the additional cost of those benefits may amount to upwards of $10,000 plus the additional malpractice insurance premium cost.

The hiring may also necessitate moving to larger office space, buying more equipment, and employing more supporting personnel (nurses, secretaries, bookkeepers, etc.). To continue the expanded practice without enough examining rooms, equipment, and lay assistance would indeed be a false economy, although a hiring physician too often tends to ignore or resist these accompanying changes. The changes may add $15,000 to $25,000 or more.

The first-year expenditures due to a new physician easily could add up to $60,000 or more. Thus, one should question how much fee income will be received because of his presence.

The new doctor will begin his employment with no patient load at all. It will take a time, perhaps several years, for him to develop a comparable volume. Even when the existing practice has an overflow of business, there may be a time delay in integrating the new physician into that activity. Finally, because of the normal time elapsed between performing a service and collecting the fee, there will be little income from the new physician's work during the first two or three months regardless of his activity—a factor which may mean only nine or ten months' income during his first full year of work.

These first-year economic factors are not intended to dissuade one from seeking additional help. Rather, they should be recognized and evaluated so the hiring physician will be able to plan his personal economics to what may be a year of lower income. This is particularly true of an incorporated physician, for the income and expense projection may indicate a need to reduce the owner's salary. Such a step is far better taken in advance than at a later date when an actual negative cash flow begins to strike.

### Promises of partnership

A common practice that has developed is a new doctor being hired as an employe for one year and then being taken in as a partner or shareholder (on a basis gradually approaching equality) beginning the succeeding year. Sometimes the new physician's employment extends two years before partnership, but rarely longer. While the initial hiring is in progress, however, one must consider how specific and how binding to make the future partnership arrangements.

We used to advise that neither party commit himself to partnership arrangements when negotiating the initial year's employment but that philosophy is changing. The supply and demand circumstances are such that the senior doctor may feel the need to secure the future deal immediately for his own protection. A young physician will have a stronger "negotiating position" a year later if he has done good work and built some patient or referrer reputation.

On the other hand, the newly hired physician needs assurance that the group or hiring doctor will not feel so squeezed by short term economics that they then offer him a less generous partnership arrangement than had been discussed. Although a prime purpose of the first year is to permit both parties to appraise the desirability of working together indefinitely thereafter, some assurances seem to be needed by both sides. Despite that, our basic "Dr. New Letter" does not include the future deal in its text. We leave that subject to be expressed separately.

### Compensation

Starting salaries range from $25,000 to more than $50,000 (and far higher for a few especially scarce subspecialties). There is no "correct" figure. The high-income specialties and many of the surgical specialties (orthopedic surgery, obstetrics/gynecology and urology, for instance) seem to be offering starting pay at $40,000 and higher. Both parties

*The authors are the principle consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pa.*

should recognize, however, that a few thousand dollars difference in first-year pay is insignificant over the longer term.

We often encourage our clients to offer an additional "incentive compensation," perhaps 40 to 50 percent of the gross or net income above that necessary to meet the cost of the new physician. Such an offer shows the new employe that the existing practice is not trying to profit financially on his work, and is instead delighted for him to benefit by any profit he generates above his basic earning level.

**Fringe benefits**

As a minimum, we believe the employer should offer the new physician basic health insurance coverage (Blue Cross/Blue Shield, or the equivalent). If the practice is incorporated, the hiring party (the corporation's owner or owners), may have medical expenses, major medical insurance, and accident and health (disability) insurance paid for by the corporation. In that event we strongly recommend that the equivalent advantages be offered the new physician. It will help show the IRS that the corporation offers its benefits beyond just the owners, and it will convey to the new employe an intent to favor him just as the owners favor themselves.

If the practice is incorporated, it also will have to consider the cost of covering the new physician in its pension and/or profit sharing plans. This can be a substantial additional cost since the plans may call for contribution up to 25 percent of the employes' salaries.

The hiring physician should be especially mindful of this cost when first discussing compensation. We advise his speaking in terms combining both current and deferred pay from the beginning. For instance, if $40,000 is contemplated from the beginning, we suggest that any discussion clearly establish that such a figure is a total combining salary and retirement contribution. It would mean a $32,000 salary and an $8,000 retirement contribution in this example.

For obvious reasons, a young physician will usually prefer cash compensation to retirement contribution. When the attorney or other pension advisors find it possible, the hiring medical corporation can give the new physician the chance to decline coverage in the retirement plan for the first few years and to receive the difference as higher salary. We call this election "opting out" of the plan. In the preceding example, the new physician may be offered a $40,000 starting salary if he wishes to elect nonparticipation in the plan. This would clearly appeal to him without costing the corporation additionally.

**Payment of expenses**

The parties should also have a clear advance understanding as to the professional expenses the employer will pay. Malpractice insurance premiums, professional society dues, and hospital staff fees most often are borne by the employer. Some senior physicians are so set back by the malpractice cost that they attempt to have the new employe bear it, but we consider it a cost which the employer should bear—even though it may affect what salary he can offer the young doctor.

Many employers also offer to pay the expenses for travel to and attendance at professional education and society meetings, although it may be desirable to place a limit on such expenditures for the year. All of these expenses seem to benefit the employer as well as the employed physician.

The hiring doctor should also consider whether to pay the new physician's automobile expenses, entertainment expenses, and the like. Especially if a professional corporation is involved and such marginally appropriate items are being provided for the present physician-owners, providing them for a new physician who is not a shareholder would help improve the argument that the expenses actually deserve the intended tax treatment.

The expenses and fringe benefits the employer pays for his new doctor should be evaluated in dollar figures, so the new employe understands that his compensation will exceed the amount of his straight salary. In fact, the employing physician or corporation often will decide to reduce the salary offer by the dollar value of several fringe benefits while strill providing the desired compensation level. A doctor willing to receive a $30,000 salary, for example, should be delighted to receive instead a $25,000 salary plus benefits which will reduce his out-of-pocket obligations by $5,000.

**Vacations and illness**

The limits on permissible absence also should be set out in advance of the actual employment. Since a person's health or vacation attitudes are difficult to anticipate such limits protect the employer. They are valuable to the new employe since he will know his absence rights and thus avoid embarrassments if and when the absences are needed or desired.

We feel that a newly hired physician need be offered only two weeks' vacation in his first year of employment. It is not unusual for clients to offer three or four weeks. The decision should depend in large part on how well the expanded practice can be maintained during absence.

As to extended absence due to illness or injury, professional practices generally are willing to allow four weeks of absence without loss of pay during the first year. Although the allowable sick leave should become longer as a physician works his way into partnership, he has not really earned extensive absence right when so newly hired. Especially if the employer carries some accident and

*Allen B. Able, M.D.* *Bertram D. Baker, M.D.*

*420 Pine St., Oldville, U.S.A.*

Norton S. New, MD
100 South Main Street
Newtown, USA

Dear Norton:

As we have discussed, this letter details our proposal for your employment. A more formal employment agreement may have to be drafted by our lawyer to meet our professional corporation requirements. We are satisfied, however, to let this informal letter set forth our understanding. It will determine the terms of any more formal document.

1. You will be an employe of our medical practice corporation for one year starting July 1, 1981. Either you or we may terminate this first year's employment at any time on 90 days' notice to the other. Only a one-year relationship is described in this letter. Although we have discussed a future relationship, no assurance of such can be made by either of us at this time. We propose to start discussions on this topic after December 31, 1981, with a firm offer (if any) and decision to be made by April 1, 1982.

2. As an employe, you will be involved full time in our practice of medicine, and you will not take any outside employment during this period.

3. We propose a salary of $40,000 which is $3,333.33 per month for your year's employment. To the extent our practice's net income (the sum of salaries, bonuses, retained income, and retirement contributions to or for us two shareholders) exceeds $190,000 during the twelve months of your employment, you will be entitled to extra incentive compensation of one-third of the excess. We are happy to share with you any such income above what we anticipate to be our break-even point on your involvement.

4. Our practice will pay the cost of your professional liability insurance, professional society dues, and hospital staff fees. We also will pay $200 per month for business use of your automobile and we will pay or reimburse you for professional education and travel expenses up to $500. Other practice-related expenses must be paid out of your earnings. We estimate the cost of these items provided by us to be $3,500.

5. Because we practice as a professional corporation, you will be entitled to certain fringe benefits. These include our payment of Blue Cross/Blue Shield and major medical insurance for you and your family, group term life insurance protection of at least $50,000, and disability insurance coverage of at least $1,500 per month after a 90 day waiting period. You have stated your preference not to be covered by our pension and profit sharing plans in the first year. If necessary, you must agree to sign a form so stating your waiver. We estimate that the package of fringe benefits for you will total $2,000.

6. You are entitled to two weeks paid vacation and to one additional week of absence for educational and/or professional society meetings. Arrangements for all absences must be made to assure that our practice is covered. Unused absences cannot be carried over to succeeding years, nor will they be paid for.

7. In case of absence due to illness or injury, your basic salary will continue for a period not exceeding 30 days plus any unused vacation time. Absence in excess of that will be without pay.

8. It is an express condition of this agreement that if your employment terminates any time during the year in question or thereafter you will not enter into the practice of medicine in any manner or capacity within ten miles of our practice's office for at least one year. We have developed a large and reliable referring physician relationship. We intend to involve you completely in these relations, but the loss of these would seriously injure our practice. This requirement is crucial. You expressly agree that this restrictive covenant will continue so long as you are employed by our corporation, and that we are empowered to enforce it by obtaining an injunction in a court of law or equity.

We hope this proposal meets with your approval, and we look forward to our working together starting July 1, 1981. If you agree to these terms and agree that they will be legally binding upon you and us, please sign one copy of this letter and return it to us. We will each then have a copy signed by the other, evidencing our agreement. Please give either of us a call at your earliest convenience if you have any questions.

Sincerely,

_____ _____

Allen B. Able, MD Bertram D. Baker, MD

Agreed and accepted this _____ day of _____, 1981.

_____

Norton S. New, MD

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health (disability) insurance on each physician or reimburses each physician for his own disability premiums, four weeks of paid absence due to illness should be quite generous at that stage of the employment relation. Whatever the limits and rights are, they should be set out in advance and respected by both parties.

Fairness to the young physician calls for some consideration of his salary if the senior doctor should become disabled. This may call for a general undertaking to reevaluate matters in such event or for a specifically agreed change in compensation. We consider this reasonable when the new doctor is joining a solo practice, but we do not usually recommend or agree with it when a group of physicians is involved.

### Restrictive covenant

We had not been enthusiastic over the years about including an agreement not to practice competitively in case the new relationship should not work out. Under such a covenant, a new physician would agree that he will not practice medicine in his employer's area for a stated period of time after his employment relation ends. In effect, the covenant attempts to assure the hiring physician or group that the employe will not leave and set up his own practice—perhaps having built up his patient following or referral sources at his employer's expense.

The traditional lack of interest in noncompetition promises came from the physicians' practice circumstances. Practices were so busy that a young doctor's defection and entry into practice would not matter. There were plenty of patients to be seen. At the time, the law of supply and demand permitted all physicians to do well.

Now, however, things seem to be changing. An existing practice cannot be so sure it will continue to grow, nor that it can avoid losing income if a segment of its patients should defect. On the other hand, a young physician cannot be so sure of being able to start a practice on his own—without first having nurtured some patients or referrers.

We are advising hiring physicians to insist more forcefully on agreements not to compete. Nonetheless, we are more understanding when a young physician shows us such a provision in his proposed arrangement. Seniors are becoming more reluctant to stake young physicians in practice at their own expense if the new physicians do not progress to partnership.

Restrictive covenants generally are enforceable in most states if reasonable as to the distance and time involved. For example, a provision which states the reasons for its inclusion and which prohibits the same specialty practice within five or ten miles for one year after departure generally will be upheld.

### Conclusion

Taking on a new physician is a matter primarily for doctor-to-doctor discussion on a mutual professional basis. There is much to consider. Some of the concerns are complex enough to require more experienced legal or business advice, but the physicians should stay in control of the situation. The new and old physicians will have to work with each other in trust and confidence hopefully for years. The "Dr. New" arrangement is just the first installment of the relationship.

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# obituaries

• **Louis Beer,** Bethlehem; Jefferson Medical College, 1951; age 63, died October 8, 1980. Dr. Beer was a general practitioner in Bethlehem. He was chairman of the Bethlehem Health Board and physician for the Bethlehem Area Vocational-Technical School.

• **Rhoda Nina Bruck,** Philadelphia; University of Pennsylvania, 1946; age 58, died October 25, 1980. Dr. Bruck was chief radiologist at Northeastern Hospital, Philadelphia.

• **Paul James Herley,** Coatesville, Hahnemann Medical College, 1940; age 71, died September 30, 1980. Dr. Herley, a general practitioner, had served as health officer for Coatesville and chief of staff at Coatesville Hospital.

• **Ammon Gross Hess,** Lancaster; University of Pennsylvania School of Medicine, 1911; age 102, died October 15, 1980. Dr. Hess had been named as the University of Pennsylvania Distinguished Senior Alumnus. In 1961 he was recognized by PMS for 50 years of medical practice.

• **Charles W. Iobst,** Bethlehem; University of Pennsylvania School of Medicine, 1943; age 62, died October 8, 1980. Dr. Iobst was a psychiatrist in Fountain Hill. He was past president of the Northampton County Medical Society.

• **James Shannon Jordan,** Scranton; Jefferson Medical College, 1930; age 77, died October 12, 1980. Dr. Jordan recently had been recognized for 50 years of practice. He was affiliated with Wills Eye Hospital and director of the Lackawanna County Association for the Blind.

• **John M. Kohl,** Norristown; Jefferson Medical College, 1948; age 56, died October 4, 1980. Dr. Kohl was director of the radiology department at Montgomery Hospital.

• **Joseph S. Matta,** Drexel Hill; Jefferson Medical College, 1950; age 65, died October 5, 1980. Dr. Matta was a general practitioner in Delaware County for 30 years.

• **William R. Morton,** Toronto, Ontario; University of Toronto, 1923; age 78, died September 1, 1980. Dr. Morton was a member of Allegheny County Medical Society.

• **Eugene P. Pendergrass,** Fort Myers, Florida; University of Pennsylvania School of Medicine, 1918; age 84, died October 1, 1980. Dr. Pendergrass was a cancer researcher and retired chairman of the radiology department at the Hospital of the University of Pennsylvania. He was professor emeritus of radiology at the university's school of medicine. He received the PMS Distinguished Service Award in 1970. He was president of Philadelphia County Medical Society and of the Radiological Society of North America and of the American College of Radiology.

• **Donald M. Pillsbury,** Rosemont; University of Nebraska School of Medicine, 1926; age 77, died October 10, 1980. Dr. Pillsbury had been chairman of the dermatology department at the University of Pennsylvania School of Medicine from 1945 to 1965. He was former co-director of the Skin and Cancer Hospital of Philadelphia and was a past president of five national associations of dermatology.

• **Frederick A. Prescott,** McKeesport; University of Pennsylvania School of Medicine, 1921; age 88, died September 25, 1980. Dr. Prescott was medical examiner for Elizabeth Township schools for more than 50 years. He was on the staff at McKeesport Hospital.

• **Max Schumann,** Philadelphia; University of Pennsylvania School of Medicine, 1922; age 83, died September 27, 1980.

• **Romualdo R. Scicchitano,** Pottsville; Jefferson Medical College, 1927; age 77, died June 26, 1980.

• **Stanley Weinstein,** Philadelphia; Jefferson Medical College, 1947; age 58, died September 29, 1980. Dr. Weinstein was an internist in Cheltenham, Montgomery County.

**William J. Crosson,** Berwyn; Temple University School of Medicine, 1934; age 72, died October 7, 1980. Dr. Crosson was a pioneer in developing the first oral contraceptive pill. He was a former medical director of Merck Sharp & Dohme and G. D. Searle Co.

**Paul H. Ulrich,** Beacon Square, Florida; Hahnemann Medical College; age 78, died October 14, 1980. Dr. Ulrich had served as physician for the Pennsylvania Railroad Company in Philadelphia and Altoona.

**Harry Williams,** Elkland; Jefferson Medical College, 1929; age 77, died September 2, 1980. Dr. Williams was a former Tioga County coroner.


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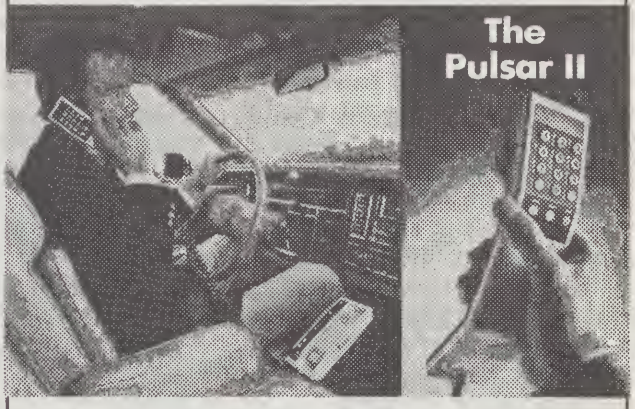


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Diagnosis of pseudomyxoma peritonei

# Combining ultrasound and computed tomography

Edward J. Pavsek, MD
Julian R. Lewin, MD

Pseudomyxoma peritonei now is acknowledged to represent a disseminated intraabdominal neoplasm. The clinical entity of mucinous ascites, whether benign or malignant, is of uncertain etiology.

Commonly it is associated with ovarian neoplasms, particularly mucinous cystadenocarcinoma, or appendiceal lesions such as mucoceles or mucinous adenocarcinoma. Visceral invasion and metastases are rare. The customary presenting complaints of abdominal distention, abdominal or pelvic masses, intestinal obstruction, nausea, vomiting, and weight loss are nonspecific and usually prompt an extensive, inconclusive work-up.

A recent report documented the ultrasound findings in an elderly patient with pseudomyxoma peritonei but no mention was made that this patient was studied by computed tomography.[1]

We have encountered a recent case of pseudomyxoma peritonei in a male patient with underlying adenocarcinoma of the vermiform appendix. The diagnosis of mucinous ascities was established rapidly and expeditiously with the aid of correlative ultrasound and computed tomography examination of the abdomen.

## Case report

A 37-year-old man was admitted on March 30, 1978 with the chief complaint of increasing abdominal girth, anorexia, and mild epigastric distress of three to four weeks duration. He had been studied initially as an outpatient.

An upper GI series, small bowel series, barium enema, and intravenous urogram before admission had failed to disclose any significant abnormality. A chest roentgenogram disclosed only diaphragmatic elevation and some crowding of the basal vascular markings. A radionuclide liver scan was within normal limits.

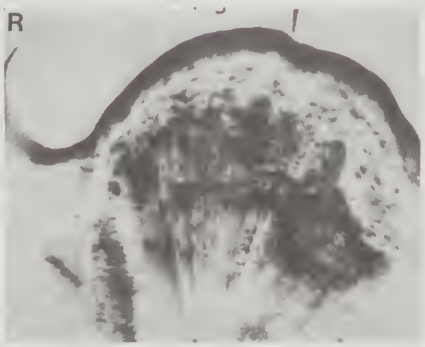


*Figure 1.* **Transverse scan showing characteristic "cake" of mixed echogenecity displacing bowel loops posteriorly, opposite to the ascites pattern.**

Physical examination at the time of admission revealed a distended abdomen, bulging flanks, "shifting dullness," and some suggestion of hepatosplenomegaly. Multiphasic screening was within normal limits. Hemoglobin and hematocrit were 11.9 gms and 37 percent respectively with 7,000 WBC and normal platelets.

The admitting impression was that of ascites and possible hepatosplenomegaly. Paracentesis did not confirm the presence of ascites. The ultrasound examination of the abdomen demonstrated an unusual peripheral band of low-echo structures which depressed and displaced bowel loops dorsally and cephalad. The peripheral distribution simulated ascites but the echogenecity of this band suggested a soft tissue pattern of a mucinous or fatty substance (Figure 1).

Computed tomography body scan was performed using the Siemens Somatom. The examination was performed without intravenous or oral contrast material. No antiperistaltic medications were used because of the rapid scan time. Scanning at 16 mm intervals was performed from the level of the xiphoid to the symphysis pubis.

This study delineated an appearance superficially simulating ascites, but certain dissimilarity was present in the distribution and density of this abnormal intraabdominal material and it failed to change its configuration with positional changes (Figure 2). These observations and the ultrasound findings raised the suspicion of the presence of pseudomyxoma peritonei.

Peritoneoscopy demonstrated diffuse intraabdominal mucinous implants. Salient material obtained at that time was believed to represent mucinous implants secondary to a mucinous carcinoma or mucocele of the appendix.

On June 8, 1978, laparotomy demonstrated mucinous ascitic fluid, a thickened omentum containing multiple cysts and tumorous infiltration, multiple cysts, and firm tumor-like material over the surfaces of the diaphragm, liver, anterior wall of the stomach and spleen and extending into the pelvis.

The vermiform appendix was identified, its tip was perforated and was exuding mucinous material. An obstructive segment, observed in the mid portion, revealed the presence of a mucinous adenocarcinoma on subsequent pathological examination. The patient received intraperitoneal

*The authors are members of the radiology department of Mercy Hospital, Pittsburgh.*
*They wish to acknowledge appreciation to Dr. Charles Copeland for providing the case material and to Helen Lordeon.*

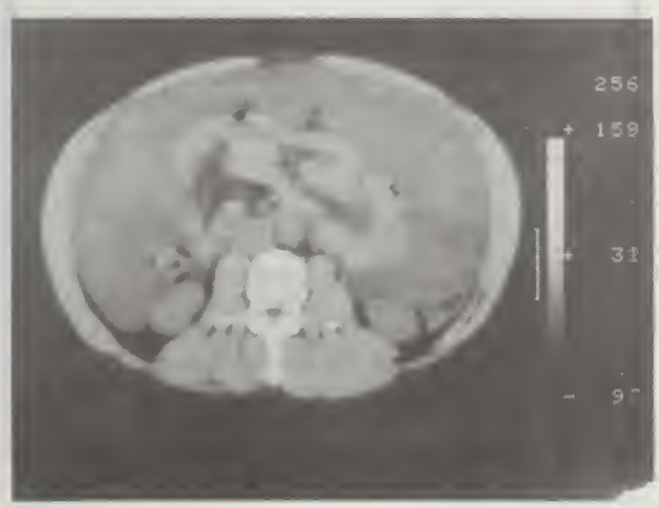


*Figure 2.* **Computed tomography scan of mid abdomen revealing atypical ascitic pattern. Centralization but dorsal displacement of bowel loops by mucinous ascites with high attenuation coefficient (20H).**

*Figure 3.* **Highlighted computed tomography scan demonstrating appearance of mucinous ascites in upper abdomen and infiltration into the area of porta hepatis.**

Thiotepa once and was discharged on June 20, 1978.

## Discussion

The combined use of ultrasound and computed tomography in the diagnosis of pseudomyxoma peritonei previously has not been reported. As anticipated, the two diagnostic modalities are complementary. Both define an abnormal material within the abdomen which superficially resembles ascites but with unique differences.

The distribution and make-up of this material produces centralization of bowel loops and inhibits the bowel from floating upward. The mucinous content of this material, intermixed as it is with small cysts and tumorous material, is responsible for producing the echogenecity by ultrasonography.

Computed tomography demonstrated an appearance superficially simulating ascites. Unlike the usual form of ascites the abnormal material lacks homogeneity and is denser than ordinary ascitic fluid (20H).

In this case, the widespread and extensive presence of mucinous ascites, through volume averaging, decreased the attenuation coefficient of all the solid organs visualized. In the upper abdominal scans, abnormal density infiltrating the porta hepatis was visualized. Its attenuation coefficient was the same as that of the mucinous ascites, as demonstrated on the highlighted scan (Figure 3).

The rarity of pseudomyxoma peritonei and the current infrequency of its investigation by combined ultrasonography and computed tomography imaging precludes any definite statement as to the specificity of these findings. It is likely that only few abnormal conditions could simulate the appearances described.

Kagel and Steckle[2] recently have reported a case of bloody ascites associated with abdominal mesothelioma studied by computed tomography. Superficially this resembles the computed tomography appearance noted in pseudomyxoma peritonei, but correlative ultrasound was not performed.

The initial combined use of ultrasonography and computed tomography of the abdomen can expedite the correct diagnosis of pseudomyxoma peritonei without exhaustive preliminary investigation. Furthermore, mindful of this diagnostic possibility, the attending surgeon can be alerted to the operative difficulties to be encountered at the time of laparotomy and the most likely site of primary pathology.

## REFERENCES

1. **Merritt, C.B., Williams, S.M.:** Ultrasound findings in a patient with pseudomyxoma peritonei. *J Clin Ultrasound 6:*417-419, 1978.
2. **Kagan, R., Steckel, R.J.:** Radiologic investigation of bloody ascites. *Am J Roentgenol 131:*697-699, 1979.

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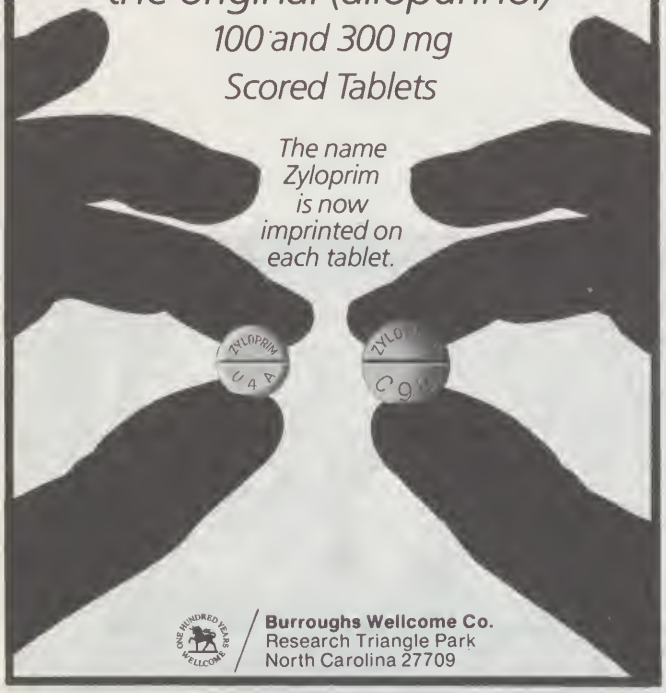


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# Clinical spectrum of endobronchial breast metastasis

C.L. Anderson, MD

The variability in the onset of metastatic symptoms is demonstrated in the four cases of endobronchial metastatic breast carcinoma presented in this study.

The symptoms themselves, chest x-ray manifestations, location of metastasis in the bronchial tree, bronchoscopic visualization, and histopathology are described. Proximal bronchial involvement which easily could be confused with a primary bronchogenic neoplasm was demonstrated in three of the cases. The fourth case presented as an interstitial disease process due to lymphangetic spread.

The knowledge that breast carcinoma can metastasize to the bronchus is not new. King and Castleman, in their histopathologic review of 20 cases of endobronchial metastasis, included five in which the primary site was breast.

Subsequent case presentations have demonstrated the endobronchial metastatic ability of breast carcinoma.[2,3] However, in a recent review of endobronchial metastasis to central airways (main or lobar bronchi),[4] representing a site of possible confusion with bronchogenic carcinoma, breast metastasis was not mentioned in the authors' case reports or in their summary of the literature of only central airway lesions. More recent pathologic and bronchoscopic reviews have noted the endobronchial metastasizing ability of breast neoplasms.[5,6]

Since the advent of fiberoptic bronchoscopy in clinical practice, not only central bronchi, but segmental and subsegmental bronchi, now are accessible to the clinician.

Breast metastasis may be responsive to chemotherapy or hormonal therapy, and therefore it is important to be aware that breast neoplasia can metastasize to the endobronchial area. Its presentation may vary not only from the standpoint of symptomatology, but also roentgenographically, bronchoscopically, and histopathologically. The following cases emphasize the not infrequent occurrence of this metastasis.

### Case 1

A 66-year-old woman was admitted to the hospital in October, 1974 for evaluation and treatment of a persistent cough. She was a non-smoker. The chest x-ray revealed a partial right middle lobe atelectasis.

Past medical history included a right radical mastectomy on December 6, 1941, with postoperative radiation therapy. A neoplastic nodule in the incision line of the right thorax was excised in 1964, and in 1971 a metastatic right supraclavicular lymph node was removed.

Fiberoptic bronchoscopy disclosed a mass of friable white tissue at the bifurcation of the right middle and right lower lobes causing a stenosis of both orifices. Biopsy of this area revealed adenocarcinoma.

The patient was placed on hormonal therapy but subsequently she discontinued the therapy because of nausea. A pathologic fracture of the right pubic bone occurred in December, 1974. The patient received cobalt therapy at that time.

She was re-admitted to the hospital in July, 1977 because of a recurrence of her severe cough and weight loss. Repeat fiberoptic bronchoscopy revealed that the left lower lobe bronchus was now stenotic. A mass of white friable tissue was noted at the orifice (Figure 1).

The right intermediate bronchus also was noted to be stenotic with the same type of tissue protruding into the lumen. Biopsy of the left lower lobe bronchus revealed undifferentiated carcinoma (Figure 2). The patient again was discharged on a reduced dose of hormonal therapy. She died shortly thereafter.

### Case 2

An 81-year-old woman was admitted in July, 1977 for evaluation of persistent hoarseness of several months duration. She was a non-smoker, too. In 1973, she had undergone a simple mastectomy for carcinoma of the right breast. Postoperative radiation therapy was given to the right anterior chest wall.

On admission, her chest x-ray was normal. Bronchoscopy revealed a paralyzed left vocal cord, and, at the carina dividing the superior division of the left upper lobe and the lingular division of the left upper lobe, there were multiple nodules of glistening white tissue causing partial obstruction to both orifices.

Microscopic evaluation revealed carcinoma. The patient refused further therapeutic intervention and died one year later.

### Case 3

A 51-year-old woman had a lobular carcinoma of the breast diagnosed in April, 1977. She was a minimal smoker of several cigarettes per week. Metastasis was present at the time of surgery, and, following radical mas-

*Dr. Anderson is on staff in the pulmonary medicine departments at McKeesport and Western Pennsylvania hospitals.*

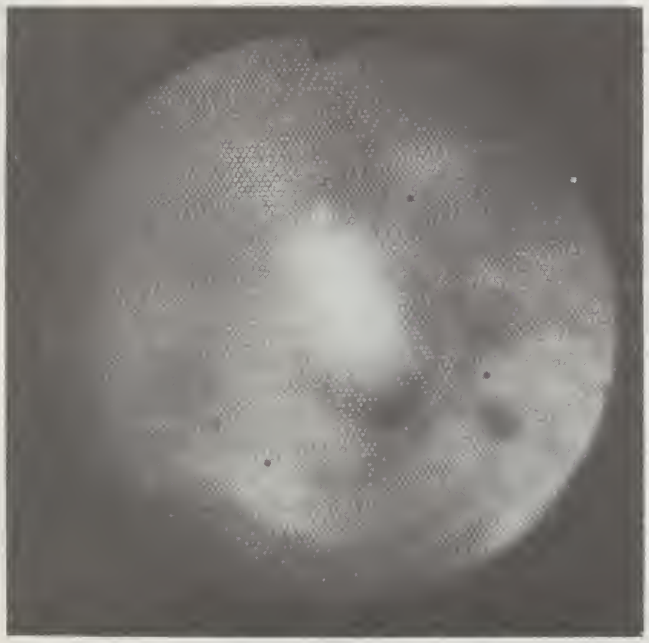

*Figure 1.* **Fiberoptic bronchoscopic view of fungating lesion of left lower lobe bronchus in patient 1.**

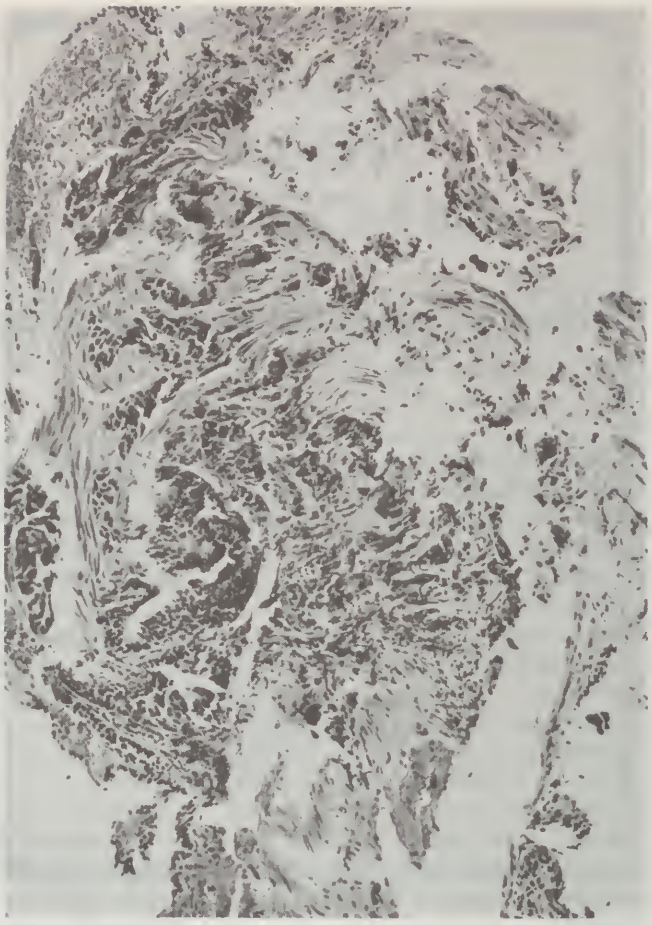

*Figure 2.* **Bronchial biopsy demonstrating infiltrating undifferentiated carcinoma in patient 1 (Hematoxylin-eosin, original magnification X150).**

tectomy, she was given a course of radiation therapy and chemotherapy, consisting of 5-fluorouracil, methotrexate, cyclophosphamide, and prednisone.

She was re-admitted in August, 1978 because of cough and shortness of breath. The chest x-ray revealed a right hilar mass with volume loss of the right middle lobe.

At fiberoptic bronchoscopy, the carina was widened. The right middle lobe bronchus appeared as a cul-de-sac with a lumen of pinhole size. Biopsy of the right middle lobe bronchus revealed carcinoma, with the bronchial epithelium intact, (Figure 3), identical in appearance to the original pathology (Figure 4).

### Case 4

A 55-year-old woman was admitted in September, 1978 because of an abnormal chest x-ray showing an interstitial pattern (Figure 5), accompanied by a persistent cough. She was a non-smoker. She had a two-month history of shortness of breath, myalgias, weakness, fever, and a cough which was treated with antibiotics and improved somewhat. The chest x-ray however, remained normal. Physical examination by several physicians revealed no breast masses. The lungs were clear to auscultation.

Fiberoptic bronchoscopy was visually normal; however, transbronchial biopsy under fluoroscopy revealed poorly differentiated adenocarcinoma (Figure 6). Subsequent mammography revealed a 2 x 1.7cm density posteriorly in the left breast against the chest wall. Biopsy of this lesion revealed adenocarcinoma, with extensive lymphatic permeation, and chronic cystic disease.

### Discussion

In three of these cases, the endobronchial metastasis readily was visualized bronchoscopically, and easily could have been confused with a primary bronchogenic tumor. The fourth case revealed endobronchial involvement only microscopically.

Although the signs, symptoms, and chest x-ray changes in metastatic endobronchial disease may be identical to a primary bronchogenic carcinoma, in most cases the clinical manifestations of the primary tumor precede evidence of endobronchial metastasis. In the first patient, there was a 33-year interval between the initial lesion and the endobronchial one, but in the fourth patient the diagnosis of metastatic lung disease preceded the diagnosis of the primary lesion. Endobronchial involvement also may be present incidentally, as demonstrated in the second patient who had no bronchial symptoms or chest x-ray abnormality despite significant endobronchial pathology.

The symptoms of endobronchial dis-

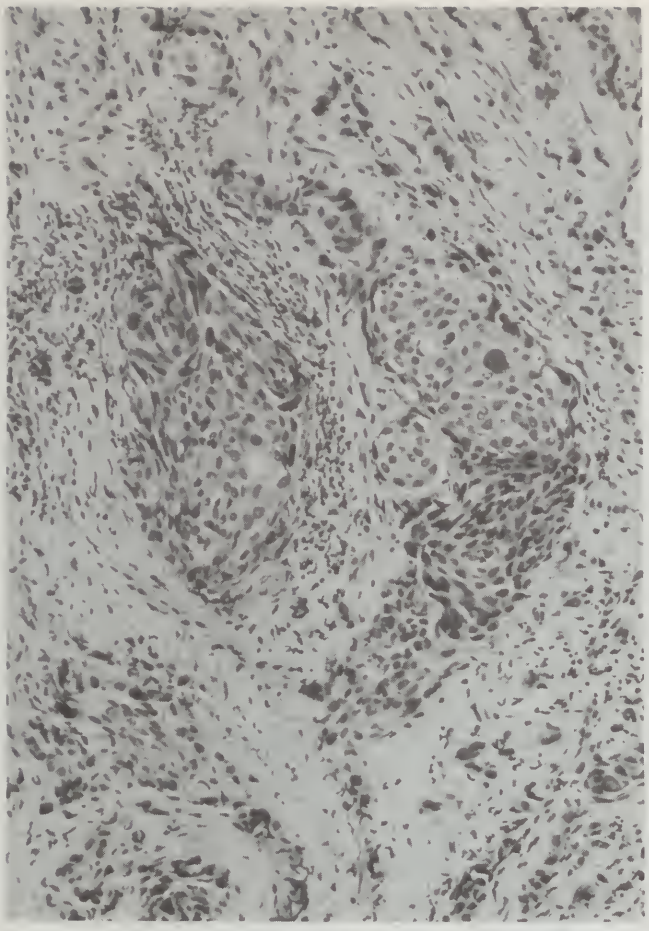

*Figure 3.* **Bronchial biopsy of stenotic narrowing of right middle lobe, demonstrating subepithelial tumor deposits in patient 3 (Hematoxylin-eosin, original magnification X230).**

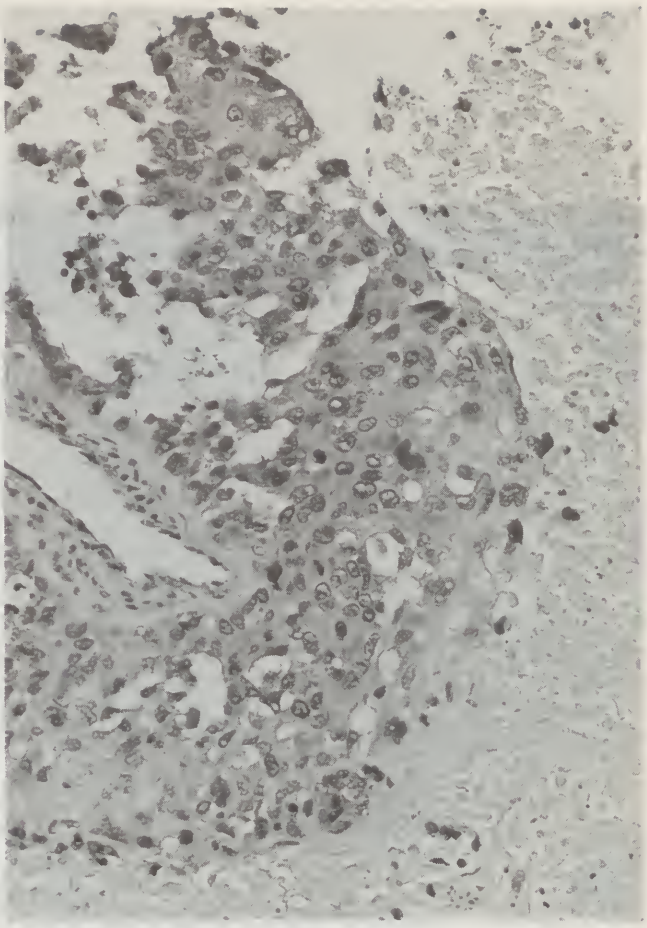

*Figure 4.* **Original breast carcinoma in patient 3 (Hematoxylin-eosin, original magnification X230).**

ease may vary. Roentgenographic findings, which may reveal a normal chest x-ray, may show varying degrees of atelectasis, infiltrates, or an interstitial disease pattern. It is prudent, therefore, to evaluate thoroughly every new respiratory symptom, or chest x-ray abnormality, in patients with a past history of breast carcinoma. As has been previously stated, bronchoscopic examination is warranted under these circumstances.[6] It should be emphasized that any part of the bronchial tree may be involved.

Bronchoscopic evaluation, itself, may reveal varying patterns of pathology. There may be a circumferential stenosis, especially of the right middle lobe bronchus, due to extrinsic nodal involvement with tumor, which has extended into the bronchus subepithelially. The obstruction is usually about 1.0cm distal to the origin of this bronchus.[7] Undoubtedly this was the situation in the third patient. With further extension, tumor nodule(s) may be visualized, as in the second patient. Finally the neoplasm may extend and rupture into the bronchial lumen, causing partial, and ultimately complete bronchial obstruction which presented as a fungating mass in the first patient.

Tumor tissue may be diagnosed as metastatic when the bronchial epithelium is intact despite tumor-filled submucosal lymph spaces.[8] The biopsy specimen of the third patient revealed an intact bronchial epithelium indicating its metastatic nature. The similarity of pathology between the primary tumor and the metastatic focus helps to establish the relationship, but it is not essential. Metastatic lesions may be pleomorphic, and suggestive of undifferentiated squamous cell or adenocarcinoma, regardless of the primary site.[8]

This was an important consideration in the first patient whose bronchial biopsy revealed undifferentiated carcinoma. Neoplastic cells were noted infiltrating smooth muscle and extending up to an intact mucosa. The history of a primary breast carcinoma with subsequent known metastatic spread also supports the contention that this lesion was metastatic.

According to King and Castleman, there are two methods by which a bronchus can be affected by metastatic tumor: direct extension from a parenchymal or mediastinal tumor mass into the bronchial wall, and direct metastasis to the wall. Most of the latter are probably lymph borne, although some may reach the bronchi via the bronchial arteries.[9] In the fourth patient, lymphogenous spread is likely, as indicated by the clinically predominating metastatic chest man-

*Figure 5.* **Chest roentgenogram demonstrating diffuse, bilateral interstitial pattern in patient 4.**

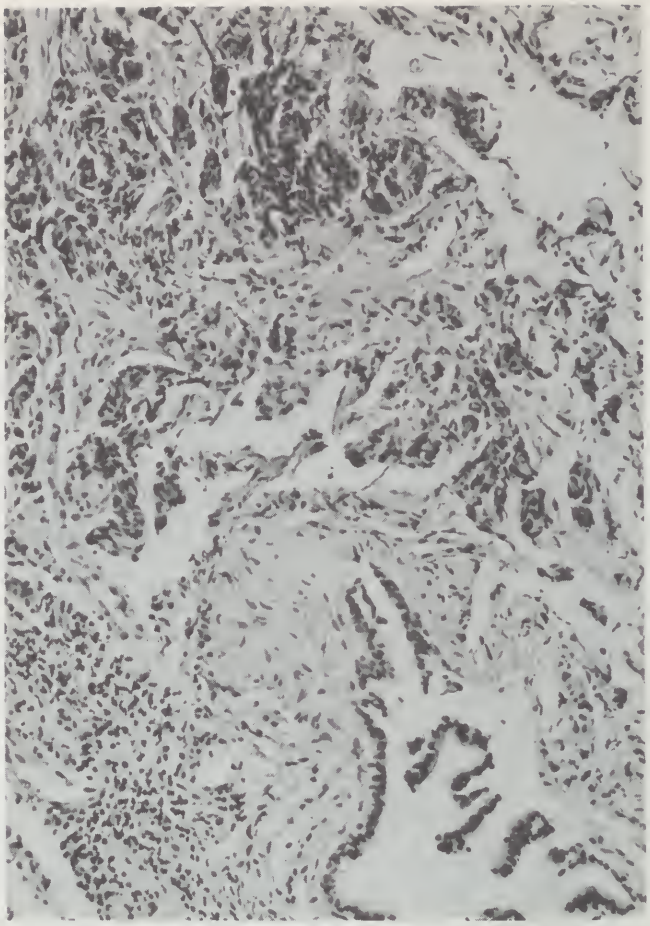

*Figure 6.* **Bronchial biopsy demonstrating poorly differentiated adenocarcinoma with intact bronchial mucosa in patient 4 (Hematoxylin-eosin, original magnification X240).**

ifestations. The chest x-ray demonstrated an interstitial pattern; however, bronchial involvement evident on the biopsy specimen, showed an intact bronchial epithelium.

The method by which neoplastic cells reach the pulmonary lymphatics remains controversial. Spencer believes that lymphatic involvement arises secondary to hematogenous emboli, with passage of tumor cells through the vessel walls, and retrograde lymphatic spread. In some instances, lymphatic spread is secondary to hilar lymph node disease and centrifugal extension.[9]

In breast carcinoma, spread may be entirely via the internal thoracic lymphatics.[10] Once the bronchial lymphatics are involved, Rosenblatt and co-authors describe the following sequence of progression:

1. distention of mucosal lymph channels with neoplastic cells;

2. coalescence of these cells to form submucosal tumor masses, resulting in bronchostenosis;

3. rupture of the tumor mass through the epithelium to form an intra luminal mass;

4. replacement of the entire mucosa with neoplasm.[11] Tumor deposits also may extend outward, producing a parenchymal lung mass.[10]

## Conclusion

These cases all demonstrated far advanced primary disease. In view of the potential responsiveness of metastatic breast carcinoma, especially those with lung metastasis, to newer modalities of treatment,[12,13] as compared with most types of primary bronchogenic tumors, the accurate appraisal of endobronchial lesion becomes an important consideration. Endobronchial involvement with breast neoplasia has been associated with survival for as long as 12 years.[5]

## REFERENCES


1. **King, D.S., Castleman, B.:** Bronchial involvement in metastatic pulmonary malignancy. *J. Thoracic Surg. 12:*305-315, 1943.
2. Case records of the Massachusetts General Hospital: Case No. 40172. *N. Eng. J. Med. 250:*733-736, 1954.
3. Case records of the Massachusetts General Hospital: Case No. 46242. *N. Eng. J. Med. 262:*1238-1240, 1960.
4. **Braman, S.S., Whitcomb, M.D.:** Endobronchial metastasis. *Arch. Int. Med. 135:*543-547, 1975.
5. **Fitzgerald, R.H.:** Endobronchial metastasis. *Southern Med. J. 70:*440-443, 1977.
6. **Tenholder, M.F., Torrington, K.G., Underwood, G.H., et al:** Letter to the Editor. *Chest 74:*320-321, 1978.
7. **Albo, R.J., Grimes, O.F.:** The middle lobe syndrome: A clinical study. *Diseases of the Chest 5:*509-518, 1966.
8. **Trinidad, S., Lisa, J.R., Rosenblatt, M.B.:** Bronchogenic carcinoma simulated by metastatic tumors. *Cancer 16:*1521-1529, 1963.
9. **Spencer, H.:** *Pathology of the lung* (excluding pulmonary tuberculosis) 3rd edition. Pergamon Press, Saunders Company, pp. 999-1010, 1977.
10. **Schoenbaum, S., Viamonte, M.:** Subepithelial endobronchial metastasis. *Radiology 101:*63-69, 1971.
11. **Rosenblatt, M.B., Lisa, J.R., Trinidad, S.:** Pitfalls in the clinical and histologic diagnosis of bronchogenic carcinoma. *Diseases of the Chest 49:*396-404, 1966.
12. **Canellos, G.P., DeVita, V.T., Gold, G.L., et al:** Combination chemotherapy for advanced breast cancer: Response and effect on survival. *Annals Int. Med. 84:*389-392, 1976.
13. **Young, R.C., Lippman, M., DeVita, V.T., et al:** Perspectives in the treatment of breast cancer: 1976. *Annals Int. Med. 86:*784-798, 1977.

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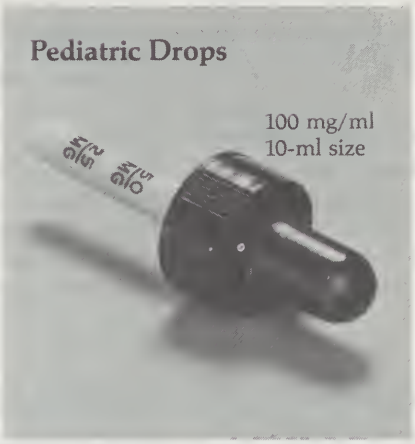


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# physicians in the news

**Henry H. Fetterman, MD,** of Allentown, recently was named to a three-year term as chairman of the Pennsylvania Section of the American College of Obstetricians and Gynecologists. He is chairman of the ob-gyn department and chief of the gynecology oncology clinic, the Allentown and Sacred Heart Hospital Center and Muhlenberg Medical Center.

**Norman J. Schatz, MD,** and **Donald E. Willard, MD,** recently received the American Academy of Ophthalmology's 1980 Honor Awards for outstanding service to the profession. Dr. Schatz is director of neuro-ophthalmology at Wills Eye Hospital and professor of neurology and ophthalmology at the University of Pennsylvania School of Medicine. Dr. Willard is in private practice in Easton.

**John F. Rose, Jr., MD,** recently was elected to the board of trustees of the American Group Practices Association. Dr. Rose is a urologist at Geisinger Medical Center.

**Maurice C. Clifford, MD,** vice president for medical affairs of the Medical College of Pennsylvania and a faculty member of the college for 25 years, recently was elected its 17th president. He served as acting president during the past year and has been clinical professor of obstetrics and gynecology.

**David G. Silverman, MD,** and **Donato D. LaRossa, MD,** recently have been awarded first prize in the senior classification of a scholarship essay contest conducted by the Educational Foundation of the American Society of Plastic and Reconstructive Surgeons. Dr. Silverman is assistant professor of anesthesiology at the University of Pennsylvania. Dr. LaRossa is with the Veterans Administration Hospital in Philadelphia.

**Willis P. Maier, MD,** has been named director of the general surgical residency program at Temple University Hospital. Dr. Maier is chief of the general surgical section and deputy chairman of the surgery department.

**Dr. Ehrlich (left) receives award from Chaplain White.**

The Chapel of Four Chaplains has awarded its Legion of Honor certificate to **Dion R. Ehrlich, MD,** for his outstanding service to the community. Dr. Ehrlich is an attending ophthalmologist at Abington and Jeanes hospitals, and is assistant professor of ophthalmology on the corneal service at Wills Eye Hospital. The Chapel of Four Chaplains on the Temple University campus, honors four chaplains of four different faiths who sacrificed their lives so that others might live when their ship was sunk during World War II.

**A. Thomas Andrews, MD,** recently was appointed medical director of the Hospice of Central Pennsylvania. Dr. Andrews, a hematologist and oncologist, is director of education and chairman of the medicine department at Harrisburg Hospital.

**Randall F. Hipple, MD,** recently was named vice chairman of the Pennsylvania Section of the American College of Obstetricians and Gynecologists. Dr. Hipple is chairman of the obstetrics and gynecology department at Williamsport Hospital and chief of obstetrics and gynecology at Divine Providence Hospital. He is also vice chairman of Williamsport's city council.

**Norman L. Loux, MD,** recently was appointed by Governor Thornburgh to the Pennsylvania Board of Public Welfare. Dr. Loux is founder and medical director of Penn Foundation for Mental Health, Sellersville.

The American Academy of Physical Medicine and Rehabilitation recently named **John F. Ditunno, Jr., MD,** president elect. Dr. Ditunno is professor and chairman of the rehabilitation department at Jefferson Medical College.

**Simon Kramer, MD,** recently was awarded a gold medal from the American Society of Therapeutic Radiologists. Dr. Kramer is professor and chairman of the radiation therapy and nuclear medicine department at Jefferson Medical College.

The Governor's Committee on Employment of the Handicapped has honored **Jack Strassman, MD,** of Altoona as physician of the year. Dr. Strassman has been a consultant to the state Office of the Visually Handicapped and the state Bureau of Vocational Rehabilitation for 28 years.

The American Academy of Family Physicians has named **Edward J. Kowalewski, MD,** the recipient of its John G. Walsh Award. Dr. Kowalewski is professor and chairman of the family medicine department at the University of Maryland School of Medicine. He is a native of Lancaster.

**Douglas M. Spencer, MD,** recently has been appointed director of the Child Diagnostic and Development Clinic of the Alfred I. duPont Institute, Wilmington, Delaware. Dr. Spencer is pediatric program director of the Moss Rehabilitation Hospital in Philadelphia. He had practiced pediatrics in Paoli and was one of the original members of the Chester County Association for Children with Learning Disabilities.

**Mario A. Candal, MD,** recently received the 1980 Allentown Human Relations Commission Unity Award.

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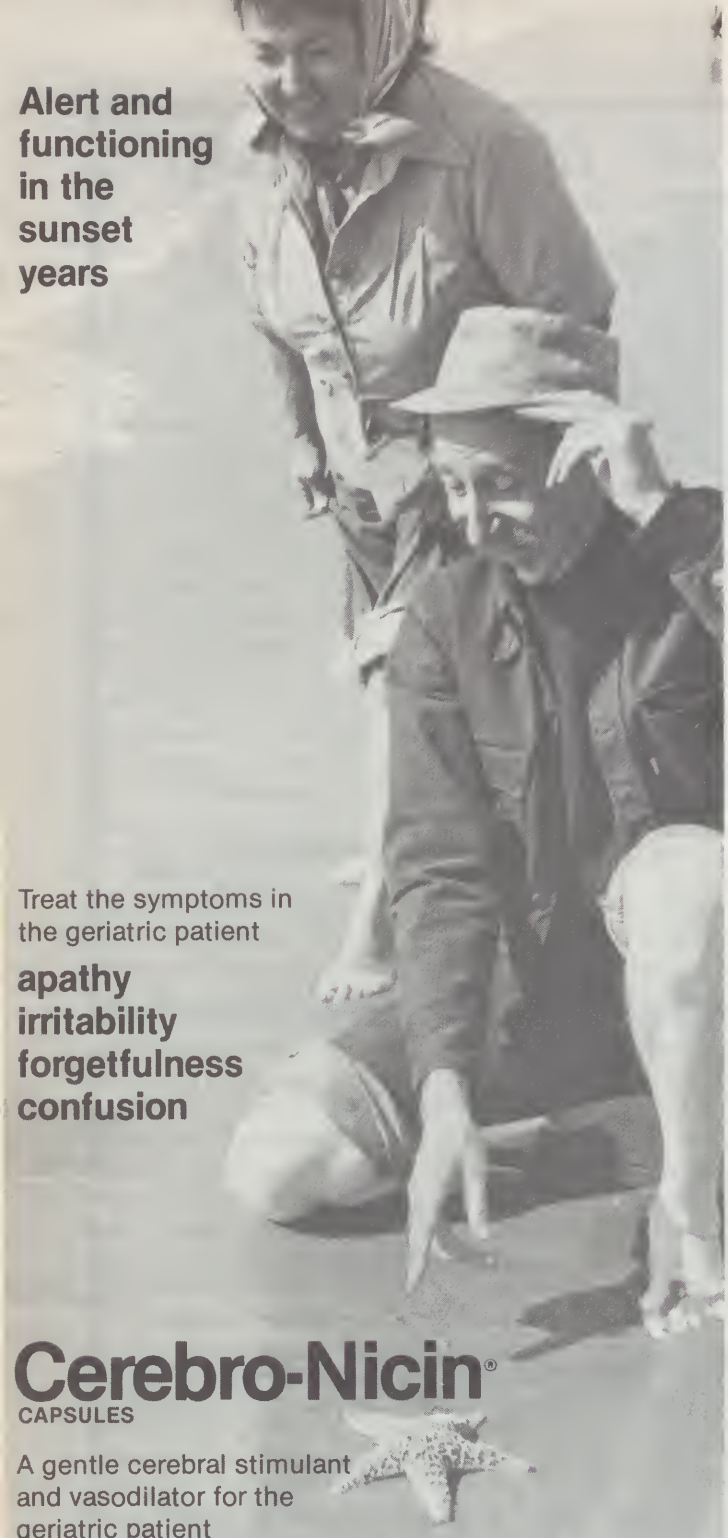

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**New Jersey-Ancora** — Immediate openings for New Jersey licensed staff psychiatrists in 1000 bed JCAH and AMA accredited psychiatric hospital. Affiliated with Temple University Hospital, department of psychiatry. Located 30 miles from Atlantic City and Philadelphia. Salary commensurate with training and experience from $33,885 to $50,435. Private practice after duty hours permitted. Liberal fringe benefits include Blue Cross, Blue Shield, and life insurance. Write Engracio Balita, MD, Medical Director, Ancora Psychiatric Hospital, Box-A, Hammonton, New Jersey 08037, or call (609) 561-1700, ext. 203.

**Grow with us in sunny Arizona** — The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Competitive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living interest you, send your CV to: Professional Relations, INA Healthplan, Inc., 6115 North 7th Street, Phoenix, AZ 85014.

**Pennsylvania licensed ob-gyn** — to join established group practice in Philadelphia area. Call (215) 887-6781.

**Camp physician** — July/August for reputable Pennsylvania camp in the Pocono Mts. State qualifications and family accommodations needed. David Blumstein, 1410 East 24th St., Brooklyn, NY 11210; telephone (212) 377-6616.

**Physician** — during July and August, 1981 for children's camp located at Beach Lake, Pa., accommodates 350 campers, ages 6-16; complete modern Health Center; 2 RNs in attendance; will accept one MD for each month; no children accepted who are of camp age. Camp opens June 27 and closes August 21. Private room and facilities. Write to Trail's End Camp, c/o Beach Lake, Inc., 215 Adams Street, Brooklyn, NY 11201, and include your phone number.

**Thinking of retiring?** — Medical directorship available, across the USA, any age physician, no fee, malpractice insurance paid, 35 hrs/wk, $35 to $40,000/yr., depending on location. List valid licenses, when able to relocate? Where? Please send resume, including telephone number. To: Fred V. Hrachovina, D.O., 1000 Second Avenue South, Minneapolis, Minnesota 55403.

**Physicians** — for clients in Pennsylvania and Massachusetts. Specialists in IM, FP, PD, ENT, diag. rad., psychiatry, physical medicine, ob-gyn, vascular surgery, orthopedic surgery, neurosurgery, and director CV med. Please call E.J. Mowry, (215) 348-8700.

**NEEMA Emergency Medical** — a professional association — Emergency medicine positions available with emergency physician group in PA, NY, NJ, VA, WVA, MD, and throughout New England, the Southeast, and the Midwest, including all suburban, rural, and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physicians department directors also desired. Please send resume to: NEEMA Emergency Medical, Suite 400, 399 Market Street, Philadelphia, PA 19106 or phone (215) 925-3511 in PA, or 800-523-0776 outside PA.

**Lovely southwestern climate** — multispecialty group seeking internist. A good situation. Contact: Talton L. Francis, Eastwood Medical Center, 10301 Gateway West, El Paso, Texas 79925; (915) 592-0201.

**Pediatrician and other physicians wanted** — for Bethel Park, Pennsylvania, suburb of Pittsburgh, 35,000 people. New professional building. Call (412) 833-6188.

**Virginia** — Primary care physician needed to join staff at growing practice in scenic Central Virginia. Enjoy well equipped facility, excellent staff, strong community support, guaranteed income, excellent linkages with hospitals and other providers in area with beautiful mountains, large lakes, and year-round mild weather. Locum tenens considered. Contact: John Troidl, Administrator, Evington Medical Center, Evington, Virginia 24550.

**Orthopedic surgeon wanted** — associate for well established orthopedic clinic in eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

**Family physician** — ABFP, young FP group in Northwestern suburb of Philadelphia (Montgomery County) seeking one ABFP physician. Practice utilizes 2 of finest hospitals in Phila. area (Abington and Chestnut Hill). Interested in quality not volume practice. To begin Jan-July 1981. Will consider board eligible resident finishing in July 1981. Call evenings Dr. Badolato (215) 572-5021 or Dr. Rosan (215) 643-6488 or write Department 849, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

**Medical group forming** — immediate attending staff physician positions available. Possible academic affiliation. Regular hours with guaranteed salary and benefits. Background in primary care, internal medicine, or family practice. Contact: Dr. Irving Abramson, Suite 400, 399 Market Street, Philadelphia, PA 19106, or telephone (215) 925-3633.

**Director** — Family practice residency program director needed for large city located in Southeastern Pennsylvania. Excellent school system (private, parochial, public) with four major colleges. Churches of all denominations including three synagogues. Numerous indoor/outdoor recreational facilities. Hunting. Within driving distance of three major cities and Atlantic Ocean. Must have administrative experience. Excellent benefit package with office space provided. Generous salary. Call or write Durham Medical Search, 505-N Statler Office Building, Buffalo, NY 14202; (716) 852-5911.

**Physician** — Large geriatric facility is seeking a full time Pennsylvania licensed physician. Job available April 1, 1981. Forty-hour work week. Liberal salary. Very attractive maintenance free home included. Full range of benefits plus fully paid malpractice insurance. Send resume to: Walter L. Wentzel, Jr., Executive Director, Masonic Homes, Elizabethtown, PA 17022. Equal Opportunity Employer.

**Pennsylvania: Western** — opportunity to assume clinical responsibilities at this moderate volume emergency department. Excellent income, flexible scheduling, and liability insurance provided. For details, send credentials to James Thomas, 230 Park Avenue, Ste. 303, New York, NY 10169, or call collect 212-599-0060.

**Surgical technologist** — or surgical assistant (P.A.). 381 bed community hospital, N.E. section of Philadelphia, Pennsylvania. Full time; salary competitive. Contact Nazareth Hospital (215) 355-6098.

**Pennsylvania, Chester** — emergency department physician for private physician group staffing EDs in Philadelphia and Delaware County. Must be PA licensed. 40 hr. week, competitive salary, paid malpractice, liberal fringe benefits, profit sharing. Send curriculum vitae to Emergency Medical Associates, Ltd., 15th & Upland Ave., Chester, PA 19013 or call (215) 874-8177.

**Obstetrician-Gynecologist** — Indiana, Pennsylvania — A beautiful university community located 60 miles north and east of Pittsburgh, PA. Indiana Hospital is a 200-bed general hospital, completing a $22 million building and renovation program, which will provide the finest in medical facilities and equipment. It is the only general hospital in Indiana County, serving a population of over 80,000. The potential for a medical practice in obstetrics and gynecology is excellent due to a strong expanding economy and a young family growth in this area which has generated the need for additional physicians in this specialty. The area has an excellent school system, fine recreational facilities with lakes, streams, and mountain terrain for the various sports. The practice opportunity is open either for a private practice or in a partnership. Inquiries should be directed to either Richard N. Freda, MD, The Ben Franklin Medical Center, Shelley Dr., Indiana, PA 15701 (412) 463-0225 or Donald F. Smith, President, Indiana Hospital, Indiana, PA 15701 (412) 357-7120.

**Staff psychiatrists** — positions immediately available. Our hospital is looking for psychiatrists with fresh ideas and strong convictions on public sector mental health care. We are located in pleasant, residential Northeast Philadelphia and can offer the area's unparalleled opportunities for professional growth and development. Good salary and benefits. Requirements are PA State license and board certification or eligibility. Contact, in strict confidence: Franklyn R. Clarke, MD, Superintendent, Philadelphia State Hospital, 14000 Roosevelt Blvd., Philadelphia, PA 19114; (215) 671-4101.

**Emergency physicians** — Philadelphia and suburban Philadelphia hospitals. Fee for service with minimum guarantee, 42 hr. per week avg. Experience preferred but will consider all applicants. Contact Teddy Trout (215) 438-0390 for further details or send CV to EMSS, 5555 Wissahickon Ave., Suite L6, Philadelphia, PA 19144.

**Pennsylvania Emergency Physician** — 200-bed general hospital located in western Pennsylvania university community. New modern Emergency Department. Salary highly competitive. PA license required. Contact: William B. Yeagley, MD, Director of Department of Emergency Services, Indiana Hospital, Indiana, PA 15701.

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**Family practitioners** — Tamaqua, northeast Pennsylvania. Area population about 18,000. Community assistance. Telephone collect (717) 668-1880 or write Tamaqua Area Chamber of Commerce, Tamaqua, PA 18252.

**Psychiatrist** — board certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact George E. Gittens, MD, Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411; (717) 586-2011.

**Family practitioner** — to join 3 physician primary care group located in Fairless Hills, PA (NE Philadelphia suburb). Full complement of laboratory and radiology services. Hospital privileges at 2 community hospitals. Excellent opportunity for aggressive individual. Mail current CV to Medical Director, Fairless Hills Medical Center, 515 South Olds Blvd., Fairless Hills, PA 19030.

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**Emergency medicine opportunities available** — Opportunities available to assume clinical and directorship responsibilities in several emergency departments located in western Pennsylvania. Excellent income, flexible scheduling, and paid professional liability insurance. Part-time opportunities also available. For details, send credentials in confidence to Mr. James Thomas, 230 Park Avenue, Suite 303, New York, New York 10169, or call collect (212) 599-0060.

**CONTINUING EDUCATION**

**Program: Pediatric Update 1981** — Sponsor: Department of Pediatrics, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY. Location: Marbella, Spain, on the Costa del Sol. Dates: February 28-March 8, 1981. Credits: 20 credits AMA Category I, 20 credits LCCME. Faculty: International faculty includes: Professor Victor Dubowitz, London, England; Professor John O. Forfar, Edinburgh, Scotland; Professor Walter H. Hitzig, Zurich, Switzerland; Professor Ettore Rossi, Bern, Switzerland; Professor R. Zetterstrom, Stockholm, Sweden. Tuition: $185; $315 MAP (full American breakfast and dinner). Information: Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042; (212) 470-2114.

**Ski and Study Weeks** — Waterville Valley Primary Care Conference (January 25-30) and Sugarbush Psychiatry Conference (February 8-13). National experts. 22 CME credits. Medical Education Conferences, Dept. P, Box 2334, Providence, RI 02906; (401) 751-0001.

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The reservation deadline is January 15, 1981. For further information call (800) 558-7990 (Wisconsin residents call (414) 327-6030) or write Dr. Jagmeet S. Soin, MD, Division of Nuclear Medicine, 8700 W. Wisconsin Avenue, Milwaukee, WI 53226, (414) 257-5968.



**Librium®** 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

*Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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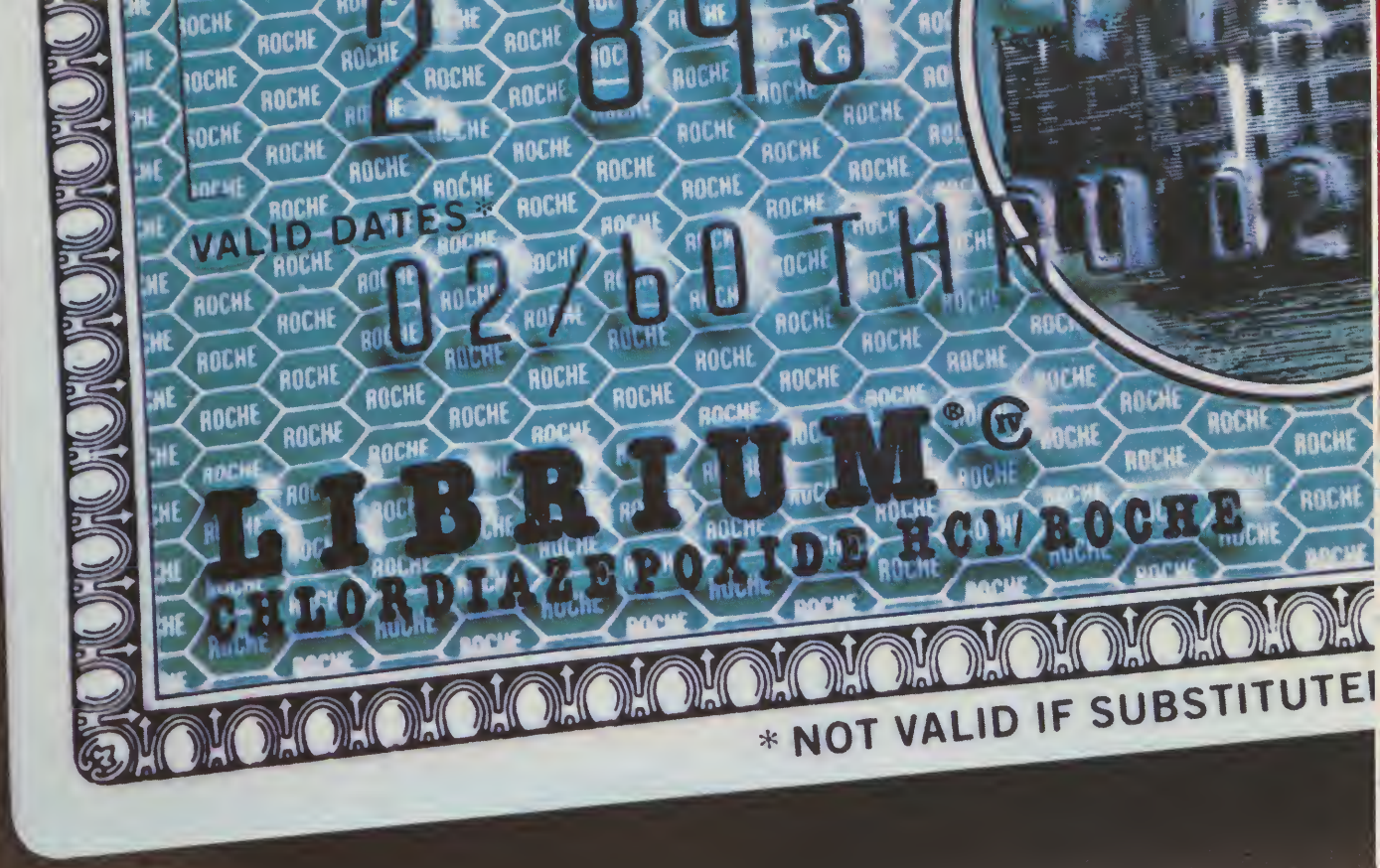


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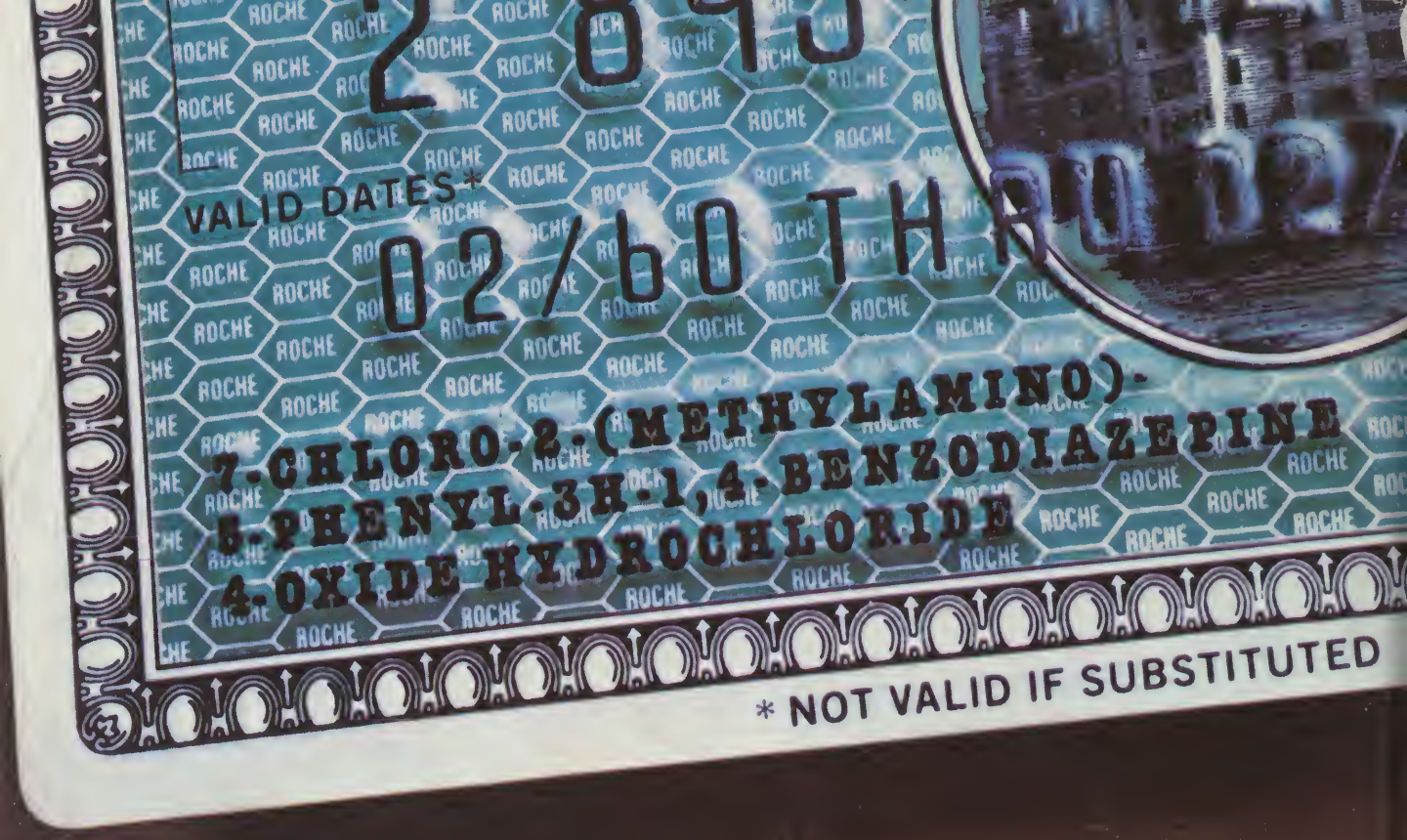


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